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ORIGINAL DEPARTMENT.

COMMUNICATIONS.

A FEW WORDS ON THE USE OF THE OBSTETRIC FORCEPS.

BY T. CURTIS SMITH, M. D.,

Of Aurora, Indiana.

While I certainly do greatly condemn needless and unwarranted interference in all cases of normal parturition, I am also one of the number who believe with many very able obstetricians of this day that the influence exerted by the old saying that "meddlesome midwifery is bad" has been the cause of great mischief in many and multiplied instances. The record of dual or single deaths resulting from the let-alone plan of management—or rather want of management—of obstetric cases, and the record of unnecessary hours of agonizing sufferings, subsequent sloughing, fistulæ, etc., all caused by this plan, would present an appalling account.

If the phrase could be allowed to have its proper limit and not constitute an established excuse for non-interference, when, indeed, proper interposition would end great suffering, or save life, or both, it would all be very well. But as stated by Dr. W. B. Atkinson (Medical and Surgical Reporter, March 3, 1877), this old saying has "caused the death of many infants and of women in labor, and the incurable injury of many others."

It is certainly not my intention in this paper to give a systematic discourse on the obstetric forceps, but in a running way to give a bit of clinical experience and a few general statements.

Most practitioners of ten years' practice know now very little of the works of Dewees, Churchill, or Baudeloque. These were the works I read while a student. They taught the use of the forceps with such scrupulous care as to measurably exclude them from obstetric practice. Only in extreme cases must they be used. Most all teachers of their day were very chary of high and frequent laudations of this valued instrument. Some eminent authorities omitted or condemned their use altogether. In the courses of lectures attended in 1861–3 the commendations of the obstetric forceps were given in such guarded language as to lead the student to eschew their use to the utmost extent. But some of our clinical lecturers were open and free in their commendation of them, and carefully precise in detailing the conditions under which they should be used and the manner of application. So between the two extremes we thought we could see there was at least a fair degree of wisdom and safety. But in this day the man who was, twenty-three years ago, considered a reckless extremist in the advocacy and use of the forceps, would be considered behind the practice of these times by a long reach.

On first entering civil practice, I secured the long double-curved forceps. I had no occasion for their use until January, 1867. Then I was called to a case that had been under the hand of a midwife all the time of labor, and a young physician of that vicinity for some considerable time. I found the head had been resting on the perineum for twenty-four hours, and for twelve hours there had been little or no pain, and of course no advancement. Stimulants, ergot, change of position, abdominal frictions, etc., had all failed. I said to the husband and physician, "The forceps must be used

here, for they are needed." I applied them, and in twenty minutes had a lusty boy in my hands, and the mother uninjured. I had but just finished the operation, when an old and highly respected physician entered. He was very discreet, but bitterly opposed to the forceps. When alone, he asked, "Do you use those things often?" "Not very." I asked, "Would you not have used them in this case?" "Never! I never had a case needing them, in my judgment." He was a fine old man and a good practitioner, but I marked him as an extremist on this subject, and from observation know he is a fair type of many fine practitioners with silvered heads now living. But I have also noted that among their lady patients very ugly gynæcological cases turn up with unwonted frequency. After the above case some months, the same physician would have given much for forceps to help him out in a case where alone they could answer his purpose.

From that day to this time I have used the forceps about eighteen times, and more frequently when called to assist other physicians than in my own practice. I have four times applied them at the superior strait. Have never had a mishap with them yet in any way whatever, except an ugly but not serious laceration of the perineum in one case, a primipara seen in counsel with an old and able physician. One case I wish to speak of more particularly. It occurred in a primipara, æt. 28. She was a large, stout brunette. Labor progressed slowly but steadily for forty-eight hours. During that time complete dilatation was effected, the liquor amnii was discharged, but there was not the slightest engagement of the head in the upper strait. There were regular uterine pains, and the contractions could be distinctly noted, but no advancement would occur. My patience was worn out. I had used ergot freely, then quinine, then whiskey, hot drinks, frictions, external pressure, and irritation of the os—finally, morphia, to quiet the pains, hoping after a rest that effectual expulsive contractions would come on. But the pains went steadily on as before, without increase or diminution in force or frequency of any special note. A very little pressure would push the head back as far as the finger could reach, thus showing the laxity of the uterine fibre. The pelvis was one of the most roomy with which I ever met, and the soft parts were thoroughly relaxed. After two days of watching (not constantly at the house, but there every few hours), I applied the forceps far up at or above the upper strait, the head actually receding under slight pressure, while applying the instruments. They locked easily, and a very little effort brought a large, strong, vigorous infant. I have never met just such a case before or since, and believe such cases are not very common in all particulars. Dr. C. H. Tidd, now of Geneva, Iowa, then my student, gave the anæsthetic for me, and made external abdominal pressure, to steady the little uterine inhabitant until I could lock the forceps on its head.

I have twice had to rest from the effort at extraction, because of the long time required and the amount of strength demanded in the process. In both instances I was relieved by a professional friend who was present, and used extractive force while I rested. I have never had the forceps to slip off, and do not believe there is any need of such accident, if the forceps are properly locked. So far I have never failed to lock the forceps without special trouble at either strait. But I know that more skillful men than I am have failed in this procedure. I have applied them often enough to know that frequently great tact is needed in their adjustment, so as to lock properly. I have always applied them as to a round ball in the pelvis, *i. e.*, without regard to the position of the child's head; but if I found the first blade disposed to lead in any certain direction, I have always allowed it to pursue its own course, and so far have always found that the second blade would as naturally assume the direct opposite of the first blade, without any special force to cause it to do so, and would therefore lock with readiness. I believe, with Dr. Atkinson (loc. cit.), that where there is any difficulty, or at least where it is quite difficult to determine the exact position of the head, it is best to apply the forceps without any reference to the position, and then by the proper use of force in the line of the natural pelvic curve the result will be fully as favorable as where great care is taken to secure the blades over the parietal sections of the child's head. Indeed, it is not always possible to determine the exact relations of the head to the pelvis, even when the head is low down. How often it occurs when called in consultation in these cases that the caput succedaneum is so extensive as to effectually cover up the fontanelles and sutures in the fœtal head, so that it feels to the touch only like a semi-solid globular mass within the vagina, and nothing more can be definitely made out of it. Shall we therefore forbear to apply the forceps simply because we cannot with certainty determine the locality of the ears of the infant in order that we may lap the forceps over them? I do not thus interpret the demands in such cases.

In my own practice, *i. e.*, exclusive of cases seen in consultation, I have used the forceps about once in every hundred cases. From this it will be seen that I am not, certainly not, an extremist in favoring their use. I am quite sure there have been a few instances where I would have availed myself of them if they had been in easy reach, and it would have been greatly to the relief the cases. I now am in the habit of taking them with me when I go miles from home on obstetric excursions, and believe we ought to do this for the comfort and safety of our patients, and of our own credit. In instances where we unexpectedly meet with eclampsia, placenta prævia, inertia, or prolapse of funis, we may, by prompt and proper use of forceps, save the life of mother, or child, or both, or prevent undue suffering, or needlessly prolonged risk of life.

The value of this instrument to the mother in cases where its use is needed or demanded is inestimable, and to the infant it is sometimes the only means by which its survival may be assured. The proper use of these implements rarely, if ever, jeopardizes infantile life. In very many instances it is the best conservator of safety for the child within our power. I believe that where the condition of the parts is favorable to the ready use of the forceps, ceteris paribus, it is better for the chances of the life of the infant to use them than to have it continue to be exposed to the dangers that jeopardize its life in cases like the first one reported in this paper. Statistics are not reliable and we will not resort to them, and my own little experience is too insignificant to base any decided opinion upon as to the point of comparative safety for the infant.

I am led to say, also, that it is my observation that women have a good and prompt getting up in cases of forceps delivery, where they are used before complete or, at least, very great exhaustion has been allowed to come on. I have never seen a lingering getting-up in such cases, whereas, I seen many of them after tedious, non-instrumental labors, and after delivery by forceps, where they were left for a long-deferred and dernier resort.

I have never seen an instance of flooding after the use of the forceps, and never but one instance of puerperal septicæmia. The most frequent cause of flooding, in my experience, has been from that form of uterine inertia incited by exhaustion from long-continued and severe labor. Indeed, I have noticed this so comparatively often that wherever I now have a case of tedious labor and do not resort to the forceps, I look out with great care for intimations of flooding, or else I precede the termination of labor by a full dose of ergot, or, better, of quinine. But I have found no use for these agents for this purpose after instrumental deliveries. Perhaps the irritation incited by the pressure of the blades against the cervix or vaginal nerves induce more prompt and thorough contraction through reflex influence.

But when we can have our own way I do not believe we ought to allow labors to become very tedious. These life-saving implements, that also may save so much intolerable maternal suffering, ought to be resorted to, "not merely to save the child, or when the mother is exhausted, but should be employed to shorten labor; to prevent the beginning of that exhaustion (*loc. cit.*); to avoid the long pressure upon the soft parts of the mother, and the consequent injury, as paralysis of the bladder, with retention of urine," paralysis of the extremities, of the rectum, and the dangers resulting from pressure on the mucous and muscular tissues of the vagina and perineum and bladder. In one case, seen some years ago, where I applied the forceps for a professional friend, and where the head had long rested on the perineum, there followed for weary weeks partial paralysis of the right lower extremity. In another case, seen more recently, where the head had been for perhaps twenty hours low down on the perineum, there was following it almost complete paralysis of the bladder for many days. I have never seen such sequences follow the prompt use of forceps, but have known them in other hands to follow tedious labors that were not instrumental.

It is a judicious practice, when we have in hand a case that is becoming tedious, and the parts are fairly favorable for it, to apply the instruments and extract the head rather than to allow even a few hours of needless suffering. Their proper use does not injure the child. They do add to the mother's safety and secure her prompt relief. I do not believe the forceps, if well handled, add to the danger of perineal rupture or laceration of the uterine cervix. A too rigid os may be injured, and on this point we have need to exercise especial care, and if need be, prolonged waiting. Chloroform will often relax a rigid os very promptly, but a rigid perineum may be very slowly, evenly, and steadily relaxed under correct and careful handling of the forceps. The only case of complete rupture of the perineum extending into the rectum I have ever had in my own practice occurred recently in a case of second labor, where the expulsive efforts of the uterus (forceps not used) were very strong and the perineum was not

allowed sufficient time to fully relax. The forceps could not possibly produce worse rupture than was there. It was repaired by two deep stitches, which secured prompt and effectual union.

As this paper was not intended as anything more than a sort of familiar clinical talk about the use of the obstetric forceps, we hope it will be accepted as such, and such only, and it shall close when I add that I never use any anæsthetic in obstetric practice but the A. C. E. mixture, which I have found to be, so far, safe, easily taken, depresses very little, and seldom nauseates, and permits a quick, full return to consciousness.

CARE OF TYPHOID FEVER.

BY J. B. JOHNSON, M. D.,
Of Washington City, D. C.

Among the many diseases which attack mankind, there are certain maladies that always pursue a peculiar course—are regular in the manifestations of the various stages of their progress, and but little modified or controlled by combinations of medicines. Intelligence and sagacity have untiringly exercised their ingenuity to produce a cure, but have, thus far, failed, and there yet remains disappointment in the success of the efforts of administering mere drugs in such diseases. Of this class is typhoid fever. The vigor of vitality is depressed by the internal presence of a poison, which acts like the process of fermentation, and starts a changed condition in the blood that alters the performance of the functions of life, and causes derangement in the actions of the mechanism of the whole system. Therefore, the diseased interruptions in the functions of life produced by the action of the poison of typhoid fever, must rely upon the inherent resisting capacity of constitutional strength for its elimination, rather than upon any real corrective agent possessed by medical art. Notwithstanding there is a vacancy in the *treatment*, and medicine has but little to offer in the *cure* of typhoid fever, an individual suffering from the disease derives great assistance from the cautious and intelligent care of a prudent physician. As a safe pilot in a hurtling storm knows the sand-bars and reefs about the channel along which his wind-tossed vessel is driven, and adroitly uses with steady skill the helm to guide it in mid-channel to a desired haven, so an experienced physician knows the organs most likely to be endangered in their functions and structure by the effects of the poison of the disease, and rationally manages his patient in a manner to escape or overcome such functional and structural changes, and thereby gives him the best chance to live, until the force of life has time to eliminate and survive the poison and its effects.

EVIL OF INTERFERENCE.

In the accomplishment of duty towards a case of typhoid fever is comprised the care and nursing of it. The *care* must be left entirely with the medical attendant, and the *nursing* with the nurse, under the special directions of the medical attendant; and in no wise must this arrangement be interfered with by either the over-anxiety of relatives or the misguided kindness of visitors. No interference whatever should be permitted, for an individual with typhoid fever, though surrounded by all the munificence that money can bestow, would have a far better chance for recovery beneath the shade of a tree, in an open field, with nothing near him but a bucket of water, than if constantly annoyed and disturbed by the overdiligence of medicine and the misplaced acts of indiscreet solicitude. What the patient needs to increase his chances of recovery are, rational medicine and careful nursing. He lies prostrated and helpless, with no expression except that of great debility. He is unable to help himself, and only arouses from his stupor when disturbed by a question, or startled by an unusual sound. When asked how he feels, he replies that he feels well; and after recognizing momentarily, in a dream-like manner, the persons and objects around him, he immediately relapses into stupor, and unless restless from active delirium, remains lying quietly in the same position, with all the functions of every organ of the body impaired and deranged. In this condition, he requires the most watchful care of both physician and nurse. Anxious ignorance is always captious and impatient; and if the kind, attentive, and intelligent physician cannot have entire control in the care of the case without being interfered with by meddlesomeness within and without the sick-chamber, it will prove far better for his reputation to quit the case and let some one else take charge of it who possesses a *cure* not only for the disease, but for meddlesomeness also. When slight, the case goes well and runs an even course; but when severe, the physician should be firm, frank, and mandatory in having his directions fully obeyed. Neglect and disobedience of the physician's advice and prescriptions have cost many a typhoid fever patient his life; and often, when too late to correct the mischief, the evil effects of disregarding the physician's admonitions have brought

their many regrets. The physician knows all the perils of the complications that may beset the progress towards convalescence; and when he warns, it is with a desire to escape such perils; and this fact cannot be too forcibly impressed upon the attention of those about the patient. He plans his treatment according to the constitution of the patient and severity of the attack, and varies it in a wise manner to meet complications. This is his special duty, and he ought in no way to be thwarted by the obtrusiveness of the advice, or interposition of the officiousness of those who do not know, and are not expected to know, either medicine or disease.

THE TYPHOID FEVER CHAMBER.

The patient should be placed in a large and well-ventilated room, containing only furniture enough for the comfort of the patient and the convenience of the nurse. The most airy room farthest from the ground floor is the best. Such a room is usually the freest from communication with the family, and will not only be most likely to insure plenty of pure air, but freedom from annoyance of the bustle and noise consequent upon the performance of household duties. No medicine whatever to act on the bowels other than the gentlest laxative should be given. Frequently individuals do themselves great injury by taking cathartic medicine in the beginning of the disease, and excite an irritation of the bowels that often requires days to subdue. The physician frequently finds a very good case of typhoid fever spoiled by the patient having taken inordinate doses of calomel, castor oil, or compound cathartic pills, under the false impression that the disease can be carried off by purgation; but this is a very grave case, and now and then renders a case fatal. The constipation can be readily overcome by giving one grain of calomel in combination with one grain of rhubarb every hour or two until the bowels are moved. Inflammation of the bowels is always a serious complication, and a wise care does nothing to excite and everything to avoid it; and when looseness of the bowels occurs with or without blood, and adds to the patient's debility, I do not hesitate to give a pill after each action, composed of one-eighth of a grain of sulphate of morphia, one grain of powdered opium, and one grain and a half of sugar of lead. The action of this pill does not often disappoint me, particularly when given after each action and continued at longer intervals after the looseness of the bowels has been checked. The patient is usually delirious, and when so, some one should always be with him. He should not be left alone for a moment, for sometimes when alone he will get out of bed and try to make his escape, and in making the effort frequently hurts himself by falls or other injuries. Nothing has appeared to me to calm this disturbance of the brain so readily as five grains of bromide of potassium and two drops of tincture of iodine in a half ounce of sweetened camphor water every hour or two during its continuance. The hair should be cut closely to the scalp in the beginning of the fever, and the patient and his friends will not object to this if told that the hair will, of itself, fall out on the disappearance of the fever. Cutting off the hair calms the patient, and allows a free application of cold cloths, and when the fever is high, no expedient so soothes as pouring, three or four times a day, two or three pitcherfuls of iced water upon the head. This can be readily accomplished by holding the head over a bucket at the side of the bed, and the patient becomes so pleased with the operation that he will make no resistance to its repetition. When the hands are dry and hot, the whole body can be cooled by placing them in a towel wetted with iced water. These are slight duties, and can be repeated four or five times a day, and will add much to the means of calming the delirium and cooling the body. In the beginning of typhoid fever, and and during its progress, there is more or less inflammation of the lungs, and this condition is not only indicated by a short hacking and frequent cough, but by the usual physical signs. This complication should be closely watched, for when serious the delirium is increased, and much danger added to the case. A teaspoonful of a mixture containing one drachm of iodide of potassium, twenty drops of tincture veratrum viride, one drachm of chlorate of potash, thirty drops of fluid extract of ipecac and twenty-five drops of fluid extract of lobelia, in four ounces of sweetened water, every hour or two, has a fine effect in allaying the inflammation and irritation about the lungs, and making the patient comfortable. The local abstraction of blood, the administration of quinine, and the application of blisters when properly indicated and timely used, are most powerful aids in the treatment of typhoid fever, and when intelligently administered, do in many cases much towards helping the patient to recover by their influence over complications; but the proposition to doctor the fever itself, by scruple-doses of quinine, the wet sheet, and iced bath, is too extraordinary to call forth serious consideration.

IMPORTANCE OF DIET.

In consequence of the more or less trouble which is so apt to arise from an inflamed state of the bowels, no part of the care of a case of typhoid fever is of more importance than that of the diet; and neglect in this particular, augments seriously the uncontrollable nature of the disease. The patient should not be allowed any other article of diet than pure fresh milk. No other drink except water should be permitted. The milk can be given iced or warmed, in quantities varying from a half to a glassful at regular intervals of two or three hours, allowing the quantity consumed in twenty-four hours to be from one to three quarts. The great advantage of milk is, that it is food already prepared by nature for the most delicate stomachs, and that, to a greater extent than any other known substance, possesses superior qualities so necessary to supply the waste of the body produced by the fever. Such mixtures as beef-tea or chicken soup should not be given during the presence of the fever. They are not only not digested, but act as an irritant, and frequently excite and continue diarrhœa. Wine, whiskey, and brandy, become sometimes of indispensable utility in extreme conditions of debility; but the probability is, that in no fever are the compounds of alcohol used with so little judgment as in this. In mild cases of medium severity, they should not be given at all; and when given they should be administered as medicine, in definite quantities and at stated intervals. As a rule, stimulants are not allowed unless the pulse at the wrist is weak and feeble, and counts one hundred and twenty a minute: and if after their administration, the patient becomes flushed and excited, the quantity should be diminished and given at longer intervals, and discontinued as soon as the emergency for their use passes off.

QUIET AND CLEANLINESS.

The patient should be kept both quiet and clean. His friends should be frankly told that the duration of his fever will probably be three weeks. This information will diminish their anxiety, and increase their patience. Quiet and cleanliness are the essential products of good nursing, and without them the sick chamber is deprived of its principal comforts. No visitors should be allowed in the sick room. They should be plainly told that their visits and company can do no good, and that by inhaling the air of the room they run the risk of taking the disease. The patient should be freed as much as possible from noise and annoyance, and the most scrupulous cleanliness, in regard to his clothes and bedding, assiduously maintained. If very ill and helpless, two beds instead of one, placed side by side, should be used for the purpose of maintaining comfort and cleanliness. All soiled clothing of both the patient and the bed should be removed and placed in a tub of cold water as soon as they become soiled, and all discharges immediately carried out and disposed of, and the vessels so used well disinfected with carbolic acid after each emptying of them. These precautions not only add much to the ease of the patient, but contribute greatly to the protection of those within the house against the power of infection. This cautious care must be unremittingly continued during the progress of the disease; and when convalescence begins, the patient must not be allowed to return to ordinary diet and usual exercise for at least two weeks after the subsidence of all typhoid symptoms. The retreat of the fever leaves the mucous membrane of the stomach and bowels in a most delicate condition, and its sensitiveness will not tolerate the slightest temerity in taking food. A single error or imprudence in diet sometimes produces either immediate death, or weeks of suffering from a dangerous and tedious relapse. Therefore, the convalescent should live upon the blandest diet. For the first two weeks he should be allowed nothing more difficult of digestion than milk, beef-tea, light broths made of chicken or lamb, rice, toast, and soft-boiled eggs, and these ought to be taken in moderate quantities, and at regular intervals. Should the milk curdle in the stomach, the addition of a couple of tablespoonfuls of lime-water to each half-pint of milk, will correct any liability of the milk to disagree, and insure a safe and nutritious diet.

INFLAMMATORY RHEUMATISM.

BY H. V. SWERINGEN, A. M., M. D.,
Of Fort Wayne, Indiana.

When the first Dr. Warren was asked what was good for acute rheumatism, he answered, "six weeks." This reply of the doctor was a very significant one, demonstrating in two words how futile was the therapeutics of this treacherous disease and how ridiculous the skill of the physician in its treatment.

It is the inglorious failure of the physician to treat successfully such diseases as this that gave birth to the lamentation of Dr. O. W. Holmes, who said that "it would be a blessing to mankind if our materia medica were cast into the sea." This is certainly a very sweeping and extravagant statement. Imperfect as our materia medica and

therapeutics is, I have the utmost confidence in it in the treatment of many diseases. I have seen constitutional treatment accomplish very much indeed, and I regard the proper exhibition of medicine of as much importance and attended with as much, if not more skill than the proper performance of a mechanical surgical operation. I have, however, never seen the "teaspoonful every three hours" change an organic into a functional disease, or raise the dead.

But I am digressing. Up to December 1, 1880, the two words "six weeks," as a rule, to which there were exceptions, constituted my treatment for inflammatory rheumatism, notwithstanding a faithful trial of all the usual remedies prescribed.

Since which time, with my new treatment, *six days* has been the limit of the duration of my cases, in every one of whom improvement was manifest before the expiration of twelve hours of treatment. It will be noticed that the second prescription is composed *entirely* of remedies usually prescribed in the treatment of the disease; it is a singular fact, however, that while I prescribed it, I presume, in every case I ever had, it was not until I gave the first prescription alternately *with* it, that I achieved such grand results; and I am not yet able to say which one of the number of ingredients is entitled to the greater credit; it is probable that the combination is more efficient than any single agent exhibited alone. I am satisfied that opium in large doses exerts more than an analgesic effect in this disease, but am inclined to give to the digestants the most important place in its therapy.

No. 1.

℞. Lactopeptin,
Pepsina (B.),
Ingluvin, āā ʒss.
Opii pulv., grs. viij.–x. or xij.
M. Ft. pulv. et in capsulæ No. xij. div. et Sig.—Two capsules every four (4) hours. (For an adult.)

No. 2.

℞. Kali iodid., ʒj. vel ʒss.
Potass. bicarb., ʒij.
Tr. colch sem.
Tr. colch. rad., āā f. ʒiss.
Tr. aurant. cort.
Syr. simp., āā f. ʒij.
Aqua menth. pip., q. s. ad., f. ʒiv.
M. Ft. sol. et Sig.—A tablespoonful in water two hours after each dose of the capsules. (For an adult.)

—A movement was set on foot at the recent meeting of the Medical Society of Virginia to organize a Tri-State Medical Society, representing the States of Virginia, West Virginia, and North Carolina.

EPISTAXIS—HOW TO CHECK IT.

BY H. PERDUE, M. D.,

Of Barnesville, Ga.

It is a matter of no small consequence to know how to check promptly hemorrhage from the nose. Occasionally we meet with patients almost exsanguinated from epistaxis, and it is apparent that we must stop the flow soon or the patient must die. The late Dr. S. D. Gross, America's great surgeon, states in his work on surgery that he witnessed no less than three persons who died from this cause. It may be the result of a blow upon the nose, plethora of the system, or the want of coagulability of the blood. It occasionally occurs in fevers, when patients are already greatly depressed, and cannot stand much loss of blood. Then it is exceedingly important that the flow be speedily stopped.

I will not recapitulate the methods laid down in works on the subject. That information is accessible to all. I will merely give one method, which, if laid down in any work, I have not seen, but which I regard as most important, as it has never failed me. It is the plugging the whole length of the nares with a piece of fat bacon or fat salt pork. I cut the meat long enough to plug the whole cavity from which the blood flows and smooth so that it can be pushed in with a twist. I tie a short string to it, so that it can be pulled out when desired. I sometimes put a piece of adhesive strip across the end of the nose and meat to prevent it slipping out, and I will state a few cases to show how effective it has proven with me.

Case 1. Mr. ——— had been sick with typho-malarial fever two weeks or more. Was very feeble. I was called hastily to see him, and found him bleeding from the nose in fast drops—almost a stream. He had been bleeding nearly an hour, and was almost exhausted. I immediately began to plug his nose, but for the first time in my life, it failed to completely stop the flow. It continued to drop, but very much slower. No time could now be spared. He was almost beyond hope. I sent a runner at once for my friend, the late Dr. G. M. McDowell, four miles distant. But I could not wait for him. I ordered some fat bacon, from which I cut a plug for each cavity, as both were bleeding. I inserted them, and in less than a minute the hemorrhage had completely stopped.

Case 2 was a bright little boy, six years old, who had been sick with typho-malarial fever two or three weeks. A profuse epistaxis properly

alarmed his parents, when they dispatched in haste for me, and I plugged the nasal cavities as soon as I could with the fat meat, and was rejoiced to see my efforts succeed at once.

Case 3 was Mrs. ———, who had been bleeding for an hour or so when I visited her. I at once adopted the same kind of measures, which stopped the flow promptly, to the great delight of the family, as they had tried every measure known to them without success.

I have tried this method in several cases besides the ones mentioned above, and have yet to record the first failure.

Hospital Reports.

A CLINICAL LECTURE DELIVERED AT THE HOSPITAL OF THE UNIVERSITY OF PENNSYLVANIA.

BY WILLIAM PEPPER, M. D., LL. D.,

Provost and Professor of Theory and Practice of Medicine in the University of Pennsylvania.

Reported by WILLIAM H. MORRISON, M. D.

Perforation of the Vermiform Appendix.

GENTLEMEN: A few days ago I had in private practice a very painful case, from which I removed this specimen, and as it is a case of great clinical interest and importance, I take the opportunity of exhibiting the specimen to you while it is comparatively fresh. The specimen illustrates one of the most frightful accidents that can occur, and one of the most invariably fatal. It is peculiarly shocking from the fact that it is very rarely suspected, that it reveals itself by few or no symptoms until the outbreak occurs, and when this does take place, there is no treatment that can be resorted to with any hope of success. The accident to which I refer is perforation of the vermiform appendix, due to ulceration, which is nearly always the result of the presence within the appendix of some foreign body or some concretion.

Let me give you a sketch of this case, the history of which agrees very closely with others that I have seen, and it has been my lot to meet with a good many of these sad cases.

This man was 41 years of age, and I suppose weighed two hundred pounds, and was the picture of vigor and perfect health. He was a hard-working man, with large business responsibilities. Hurried in his habits, he had fallen into that practice, so common with business men, of eating his meals rapidly, although at regular hours. A member of his family afterwards told me that the rapidity with which he ate was amazing, six or seven minutes sufficing for a hearty dinner of soup, meat and potatoes, followed by currant pie, and during the dinner two or three goblets of rich Alderney milk, a meal that ought to have occupied at least three-quarters of an hour. There had been no disturbance of the bowels whatever. During the summer it had been noticed that he did not seem to be as well as usual, that he was less vigorous and did not take as much interest in his affairs; and with this there were occasionally little cutting pains across the abdomen, so much so that his friends advised him to consult me, but this he did not do. Here, then, we have a man getting out of condition, and presenting slight symptoms of indefinite digestive irritation, but without any positive disturbance or derangement of the bowels. There would have been nothing in these symptoms to lead us to suspect the seat of the trouble. There had been simple irregular, shooting pains through the abdomen.

One day, feeling less well than usual, he ate such a meal as I have described, and then went for a drive. While in the carriage, he had severe pain in the abdomen and vomiting. He returned home and took to his bed. I was absent from the city at the time, and another physician was summoned. He found the patient without distinct fever. He no longer complained of much pain in the belly, but continued to vomit occasionally, the matters consisting of gastric mucus with particles of the meal which he had taken. There was little tenderness, but already there was some distension of the belly. Regarding it, very naturally, as the result of this indigestible meal, the physician ordered minute doses of calomel with soda, viz: one-eighth of a grain of calomel with four or five grains of soda every two or three hours, absolute rest in bed, and a restricted liquid diet, given in small quantities.

The following day the bowels were moved sufficiently, and the powders of calomel and soda were continued through that day and the next. He was still kept in bed, but expressed himself as feeling better, but he did not look well. There was something in his appearance which warned one that he was going to be ill. The temperature was very slightly raised, the pulse was not much increased in frequency, but the abdominal distension had increased to an unreasonable degree. There was not much tenderness on pressure, but what there was, was referred to the cæcum more than elsewhere. On the third day the symptoms were mitigated, with the exception that the man looked badly and that the belly was more swollen.

The attack having occurred on Sunday, we have thus reached Wednesday. On this day, there was again a movement from the bowels, in which there was a considerable amount of mucus, but no evidence of dysentery or diarrhœa. It seemed as though the mucus might have come from some spot of catarrhal irritation quite high in the bowel. Vomiting again appeared, although the patient had been kept perfectly quiet and fed with the greatest possible care. Before vomiting appeared, there was a good deal of pain complained of in the right iliac fossa. The temperature had been 100.5° and 101°, but it now rose to 102°. After the first day the pulse had become abnormally frequent. The vomiting at this time was not such as comes from undigested matters in the stomach, but was irritative in character; that is, he would gulp up mouthfuls of liquid stained with bile, without previous nausea. After resting a while, the vomiting would return. Several remedies were tried, but the vomiting continued through Thursday, Friday, and Saturday, and was only relieved by the use of morphia hypodermically. Even after the vomiting was checked,

the stomach was hardly retentive, only the smallest quantities of liquid nourishment being retained. The distension of the abdomen had gone on increasing until on Friday, and still more on Saturday, it was really enormous, the epigastrium projecting almost vertically from the plane of the body. The abdomen was tympanitic all over, with only indistinct tenderness, this being more marked, as all the symptoms of pain and tenderness had been in the right iliac fossa than elsewhere, but at the same time it was never definite. There was never any local swelling, prominence or dullness on percussion in the region of the cæcum. The tongue was red, slightly dry, and slightly coated. Delirium began to be evident during the nights of Friday and Saturday, but it was doubtful whether it came spontaneously or from the action of the morphia.

I returned to the city on Sunday, the eighth day of the disease. When I saw him the pulse was exceedingly rapid, from 130 to 140, and his temperature was 102.5°. The matters which had been vomited for the previous forty-eight hours had, I will not say a positive, but an indistinct fæcal odor. They were very filthy-looking, resembling dirty gutter water, with a horrible odor, which I think was mixed with a fæcal odor. The extremities began to be cold, and the nose was slightly cool. Nutritious enemas were given and retained. A blister was applied to the epigastrium, and morphia given to control pain. Nothing produced the least effect upon the symptoms. On Monday there was some evidence of effusion in the distended belly, and a little dullness was discovered in the flanks. It was, however, impossible to turn him on his side in order to prove positively that of which we were already certain, that the effusion was liquid. On Tuesday, the tenth day, he died. Towards the close there was an increase of delirium, requiring restraint by several men.

Here then was a case which began in a very abrupt and unexpected manner, in a man apparently in perfect health. As you will see, the symptoms from the first were very vague, and there was little to localize the disease in any special spot. It was rather from knowing the danger of such an accident than from any specific charac ter of the symptoms, that the diagnosis was made before death. What else could have brought on such a sudden and general peritonitis? There was no traumatic cause. The attack had not occurred during the course of typhoid fever, when ulceration exists and perforation may occur. It is true that there might have been suspected an ulceration of the intestine in this case, for ulcers in the jejunum or high in the ileum do occasionally occur with very obscure symptoms, so that until the occurrence of profuse hemorrhage or perforation, the existence of these ulcers is perhaps not suspected. These ulcers occur in patients with constitutional syphilis, in patients with scrofulous diathesis, and they sometimes occur after severe traumatism to the skin, and at times they occur without any definite cause. In such cases there may be a sudden gush of blood from the intestine or sudden perforation, with only vague symptoms having been previously complained of. In the present instance, the symptoms were not such as to indicate an intestinal ulcer. There was no passage of blood; there was no diarrhœa, and there had been none. The symptoms in the early stage were not severe enough to indicate that the walls of the intestine had broken. For two or three days after the first attack of pain, this man felt very comfortable, and it was only his pinched look and swollen abdomen that led the sagacious physician to think that the man was going to be ill. Of all parts of the intestinal canal, the cæcum is the most unfortunate in its structure, and most exposed in its position, and from its physiological functions the one where troubles most frequently occur. Usually, the symptoms that mark these attacks located in the cæcum or appendix are sufficiently localized to call attention to the right iliac fossa. We divide these diseases into those which attack the cæcum, which are called typhilitis, those which attack the cellular tissue around the cæcum, which are called peri-typhilitis; and those which affect the appendix vermiformis. Sometimes all these parts are involved, while at other times only one of them is attacked. Typhilitis and peri-typhilitis, although bad enough, are far less serious than affections of the appendix. They begin with pain, usually distinctly marked in the right iliac fossa, with vomiting and with evidence of intestinal irritation, followed by intestinal obstruction, with tenderness, possibly a distinct tumor in the right iliac fossa, distension of the belly, fever, rapid pulse, or in other words the symptoms of localized peritonitis, which has its location in the right iliac fossa. I shall have the opportunity in some future clinic of pointing out the course of these cases, but fortunately they are nearly always capable of being treated successfully. In the early stage they demand a rigid antiphlogistic treatment, and this frequently aborts the disease. If this plan is not adopted, the inflammation often runs on to suppuration, and then the abscess is to be opened early and drainage instituted. When, however, the appendix is the seat of the inflammation, the disease runs a different course. Nearly always it will be found that the affection of the appendix has been preceded by the presence in that structure of a foreign body which has gained entrance, excited inflammation, and then cannot get out. The inflammation goes on to suppuration, and when the ulcer reaches the peritoneal surface the symptoms appear, and if perforation occurs, general peritonitis is developed.

We have then a period usually of previous local disease, but the bowel symptoms may not be acute, or, as in the present case, they may be very insidious.

At the autopsy in this case, the entire body was found to be healthy with the exception of the abdomen. Here was found general peritonitis with moderate effusion, the evidences of inflammation being most marked towards the right iliac fossa. There was no circumscribing membrane, and there had been no attempt at the formation of such a membrane to separate the abscess from the peritoneal cavity. Had such a wall formed, the man's life might have been saved. When the appendix becomes the seat of ulceration, there is rarely, owing to the freedom of movement of this portion of the bowel, any attempt at the formation of a protecting wall. In the case of

inflammation of the cæcum, a membrane is usually formed which prevents the escape of the pus into the abdominal cavity. In the midst of these fetid inflammatory products we found the appendix. It was very greatly discolored, and on picking it up, it presented two distinct perforations, and on pressing it, a body about the size of a cherry-stone was found in its cavity. The appendix was opened, and its interior presented the evidences of long-standing catarrh. Its walls presented great thickening, hardening, and contraction. This condition continued for one inch from the cæcum. Beyond that point, the walls of the appendix were comparatively thin, the mucous membrane rough and destroyed by ulceration, and, as I have said, at two points perforation had taken place. Here, then, there had been chronic diseases of the appendix dependent on the presence of a foreign body, going on to ulceration and perforation.

In order to show the character of this concretion, I have had it embedded in parafine and a section made. It was a flattened oval, of the shape of a cherry-stone and so hard that when dropped to the floor it rebounded. From this section it is seen that it is laminated and is a concretion formed by the deposit of alternate layers of intestinal mucus and hardened fæcal matter. The vast majority of bodies found in the appendix, which are described as foreign bodies, such as date stones, prune stones, cherry stones, and so on, would be found on careful examination to be formed from layers of mucus and fæcal matter.

The diagnosis which was made in this case as much from exclusion as from any positive symptoms, was entirely verified by the post-mortem examination.

Let us return for a moment to what I said about the inevitably fatal termination of this affection. I have indicated how, in the case of typhilitis and peri-typhilitis, a favorable termination may, as a rule, be secured by proper and vigorous treatment. When you remember that in diseases of the appendix, there is scarcely any attempt made to limit the disease, and that as soon as ulceration and perforation take place, the inflammatory matters escape into the peritoneal cavity, and general peritonitis results, you can readily understand that the disease is necessarily fatal. What treatment could be resorted to? Of course, it occurs to you that if we knew that there was a concretion in the appendix, that as soon as symptoms showing that ulceration was progressing made their appearance, the belly should be opened and the appendix ligated and removed. This might be done in a certain number of cases with a reasonable amount of success. But how could this condition be suspected before the outbreak occurs? Who would dare to suggest such an occurrence from the slight and indefinite symptoms usually present? Probably in ninety-nine cases out of one hundred they would be entirely explained by an acute catarrhal attack. I say, who would dare, under these circumstances, to suggest such a serious complication? No one. It is only when perforation has occurred, and general peritonitis has developed, that you can recognize the nature of the trouble, but then the time for operating has gone by. The only thing that would afford any chance would be to open the abdomen, wash out the inflammatory matters, and attach the diseased appendix to the abdominal wall, as you would in operating in the case of internal strangulated hernia. I need not say that such an operation performed after these symptoms of general peritonitis had made their appearance, would be almost invariably fatal. You hardly ever have such positive assurance of the occurrence of the accident, as to justify such extreme measures. I am one of those who strongly advocate the opening of the abdomen in cases of intestinal obstruction. I think that we are not justified in allowing any human being to die where we can diagnose intestinal obstruction, even although we cannot absolutely localize its seat without giving him the benefit of this operation. Just in proportion as the symptoms are dependent on mechanical obstruction, and not on inflammatory disturbance, are we called on to operate. Just in proportion as the symptoms are indicative of diffuse inflammation and not of local obstruction, do the chances of a successful result from the operation diminish. In the cases to which I refer, the argument against the operations reaches its maximum force. There is perhaps no condition in which abdominal section holds out so little promise, as in this affection of the vermiform appendix. You will, I have no doubt, agree with me that this is one of the most startling, one of the most insidious and one of the most invariably fatal accidents that can befall any one.

It might be expected that this accident would occur more frequently than it does. It is probable that foreign bodies are going in and out of the appendix at all times, but its mucous membrane is lubricated with a smooth, viscid mucus, which prevents their lodgment. So long as the lining of the appendix remains healthy, it is difficult for lodgment to take place. It appears to me that some local disease is needed, and that this is especially induced by improper habits in eating. If the cæcum contains a mass of coarse, hard, imperfectly masticated food, a local catarrh is finally established, which also involves the appendix. There is thickening of its coats, enlargement of its calibre, and some alteration in the character of its contents. These concretions may have their origin in the appendix as the result of the disease of the mucous membrane, beginning around a small nucleus, layer after layer is deposited, until the concretion assumes the proportion of a large calculus. I believe that local disease is necessary to enable these concretions to form or be lodged in the appendix. Of course, where a foreign body, as a seed of some kind, is demonstrated in the appendix, we must admit that it has entered and set up irritation. I think that in the present case the body has resulted *in situ*, and is due to the disease of the appendix.

One of the lessons to be learned from this case is, that food is to be eaten at regular intervals, and above all things should be thoroughly masticated. The more you study this matter the more you will find that not only this, but many other diseases are developed from a neglect of these rules. I shall have frequently to call your attention to the enormous influence of this habit of bolting illy-chewed food, as a factor in the production of intestinal diseases of the most varied type.

MEDICAL SOCIETIES.

CHICAGO MEDICAL SOCIETY.

Reported for the MEDICAL AND SURGICAL REPORTER by LISTON H. MONTGOMERY, M. D., Secretary.

Regular meeting, September 1, 1884, at which the following papers were read:

"Remarks on Aneurisms," with exhibition of a specimen involving the arch of the aorta and aortic valves, by Dr. J. A. Robison.

"Recent Treatment of Asiatic Cholera as in Vogue in Southern India," by Dr. H. M. Scudder.

"Remarks on Aneurisms" is the title of a paper read by J. A. Robison, of which a few of the principal points are herewith appended. We will omit referring to the etiology, pathology, or diagnosis of aneurisms. The general principles governing the treatment, have been to prohibit the patient from taking much exercise, to secure as nearly as possible absolute rest, and to restrict the diet. When the heart was tumultuous, cardiac sedatives were exhibited, and such symptoms as dyspnœa, pain, etc., etc., have been met with appropriate palliatives. The first attempt at specific treatment for internal aneurisms was employed many years since by Albertini and Valsalva, and has been known as Valsalva's method. It consisted in weakening the patient by repeated blood-lettings, and by gradually diminishing his meat and drink till only half a pound of pudding was taken morning and evening, with only a measured quantity of water, so that at last the patient was so exhausted he could not lift his hand from the bed in which he was ordered to lie from the commencement of the treatment. When this stage was reached, the amount of nutriment was increased until the patient's strength was restored, but this plan of treatment did not yield the beneficial results which were anticipated. In our day it would be regarded as barbarous were we to try and enforce this treatment to the extreme which Valsalva reached. A modification of this method, consisting of enforcing absolute rest and diminishing the food and drink so as to diminish the quantity, but not the physiological quality of the blood, has benefited a number of cases, if not entirely cured them. While some physicians have refused to employ the depleting treatment, they have resorted to measures fully as severe. Dr. Murchison and Mr. Moore, of England, have recommended, and in one case tried, the introduction of fine wire into the aneurismal sac, on the theory that the large amount of surface exposed to the circulating fluid would produce coagulation of the fibrine.

In the case referred to, they introduced twenty-six yards of fine iron wire into the aneurismal sac, and it is needless to say that the treatment was unsuccessful, although they contend that the result obtained demonstrated that the principle was sound, and that further experiments were justifiable. A much less dangerous, and probably more efficient mode of treatment is by electrolysis. Pravaz was the first to use electrolysis for reducing external aneurisms, and Cinicelli and others have applied it to internal aneurisms, but with very indifferent results; in eight cases of thoracic aneurisms, only one was benefited. Only one case of abdominal aneurism was cured, and the patient died from rupture of the sac on account of premature exertion. The results obtained from the use of the galvano-puncture have not justified us in expecting to hope for much from that method. Professor Langenbeck, has published accounts of two cases, which he claimed to have cured by hypodermic injections of one-half to three grains of Bonjean's watery extract of ergot every three days. Balfour says he has tried this method frequently, but without any success, although he was positive that his ergot was active.

Pressure as a mode of treatment is wholly inapplicable to thoracic aneurisms, and rarely to abdominal aneurisms. Dr. Murray records a case of the latter, in which pressure on the aorta for five hours, the patient being under chloroform, was successful.

Treatment of internal aneurisms by the administration of iodide of potassium is conceded by Flint and Bromwell, and it is insisted on by Balfour, that the iodide of potassium is the only drug which offers any hope of cure, and in every case it will relieve distressing symptoms. This author says: "Of all the various modes of treating internal aneurism there is not one, hitherto mentioned, which is not attended with considerable risk or danger, except Mr. Tufnell's plan of perfect rest, while the advantage to be derived from some of them are, to say the least, very problematical."

The writer claimed that the treatment by the iodide of potassium is perfectly safe and free from all risk, and it is equally certain to afford relief, although relief is not always to be got instantaneously. It relieves the pain and other symptoms of aneurisms, more rapidly and more effectually than any other treatment, apart even from the powerful agency of the recumbent posture. The relief to the pain and other symptoms is so great, and so speedily obtained, usually from the action of the drug alone, that it is often difficult to get the patient to submit to any restrictions. The author has employed this method of treatment during the last eight years, in a very considerable number of cases, with unvarying success, so far as the relief to symptoms is concerned, and with such favorable results as to retarding the further progress of the case, and even in some cases promoting an apparent cure, as certainly to stamp this treatment as one of the most efficient hitherto propounded for the relief of this intractable complaint. Balfour relates the history of twelve cases treated by this method with the following results. The symptoms, such as pain, dyspnœa, etc., were relieved in every case. The physical signs of aneurism were diminished in seven cases; pulsation of the tumor ceased in two cases, diminished in four, and was apparent from the commencement in six. The aneurismal tumor disappeared in three cases, and diminished in five. The bruit disappeared in two cases, and diminished in two cases, but never existed in two cases. Five of the patients were so relieved that they could work, four were discharged at their request, feeling well, one patient absconded, and the result of treatment is not known. Five cases were termed cured, and seven were relieved. One of the twelve cases referred to was an aneurism of the innominata artery, which was cured, and Bal-

four claimed to have cured several cases of aneurism of the artery. One of the four cases discharged at their own request was under treatment three different times, being discharged twice at his own request, but died suddenly while under the third course of treatment. The autopsy revealing an aneurism of the aorta which had ruptured into the lower lobe of the right lung. One of the twelve cases was diagnosed as a weeping aneurism, implicating the origin of the left carotid and communicating by a small opening with the left bronchus, the patient on admission expectorating arterial blood, but this soon ceased and the patient was discharged cured. While the writer did not believe he was justified in being as enthusiastic in praises of the iodide of potassium treatment as Balfour, he believed he was justified in relating the following case, and giving iodide of potassium the credit of prolonging the patient's life and making his days comparatively comfortable.

John H. C., aged 40, a blacksmith, was first seen March, 1883. Had had several attacks of inflammatory rheumatism several years ago. In February, 1883, he was attacked with severe pains in the chest, in the præcordial region, and was treated by his physician for rheumatism for some weeks. Dr. J. P. Ross saw him, and diagnosed aneurism of the aorta. At this time the patient had a good deal of dyspnœa, some hoarseness of the voice, and quite a little difficulty in swallowing solid food. When fatigued the pains in his chest were excruciating. No tumor was perceptible, although there was pulsation in the upper sternal region, and dullness upon percussion over the area of pulsation. Two months afterward, there was a swelling in the upper sternal region at the junction of the left first and second ribs, about the size of a silver dollar. A very slight bruit was heard. The voice was very husky, and the difficulty of deglutition had increased, until now the patient could take no solid food whatever. He had emaciated, and was losing strength very rapidly. He was ordered to lie in bed continuously, and was given fifteen grains of iodide of potassium three times daily, gradually increasing the dose until signs of iodism appeared. It was truly remarkable how soon after this plan of treatment was inaugurated, the patient expressed himself free from pain and the distressing symptoms from which he had suffered. He persevered this way until May, when he said he was so well, and weary of the bed, he would like to sit up. Leave was granted. A few weeks after the writer was surprised to see him walk into his office. He complained of nothing, but cautioned him against such rash experiments, and told him to return home, and take better care of himself. His condition at this date was as follows: The continued pulsation of the tumor against the chest wall had produced absorption of a large portion of the manubrium, and an inch of the inner portion of the left first and second ribs. Consequently we could feel the pulsation of the tumor through the chest wall at a point where only soft tissues intervened. No bruit was discernible. On laryngoscopic examination there was found complete paralysis of the left vocal cord. His voice was anserinous. During all these months he had been taking the iodide of potassium without any disturbing effects until now, when he complained of symptoms of iodism. He was permitted to discontinue its use. From the date of this office visit the patient grew rapidly worse. He rapidly emaciated, dyspnœa and dysphagia increased, and finally he died of asthenia, July 19, 1884.

Autopsy.—On opening the thorax a large aneurismal tumor was seen behind the sternum about five inches in diameter. Friable adhesions of the sac to the sternum were broken up when the sternum was removed. Absorption of a large portion of the sternum and the left, first and second ribs had taken place. Heart and pericardium were normal. Adhesions between the aneurismal sac and the left lung. The left lung was pressed upward and backward into the left pleural cavity and collapsed. On opening the heart we found the aortic valves roughened. Extending the incision into the arch of the aorta, it was dilated, and at the anterior portion of the arch between the origin of the innominata and the left carotid arteries an opening, oval in form, one inch by one inch and a half, into the sac of the aneurism. Through this opening the wall of the aorta was continuous, forming the wall of the aneurism. The tumor was firm, being composed of coagulated fibrine, which was then exhibited. The recent specimen was an unusually large sac, and was informally commented upon.

DISCUSSION.

Dr. E. F. Ingals said he was much interested in the case cited in the paper for he had during last April been consulted by the patient, and found all the symptoms present as the writer had described. The speaker informed the man that he was under the best medication that could be devised, and told him to return to his physician. He then briefly gave the history of a case of aneurism of the abdominal aorta where the iodide was given two-thirds of the time for two years, with loss of bruit, cessation of pain, and decrease in the size of the tumor fifty per cent. He had recently seen this patient, and there is no return of the symptoms. He also treated a case similar in every respect three or four years ago with the iodide of potassium, and the pain was readily relieved. A case of thoracic aneurism that he treated three years ago by giving the iodide in twenty-grain doses, died suddenly soon after he saw the patient. He was at present treating a case of abdominal aneurism wherein the enlargement has been reduced fifty per cent. The speaker inquired of any of the members how long this remedy could be given continuously without injuring the mucous coat of the stomach or impairing the function of the kidneys. One year ago he began treating a case of stricture of the trachea by giving 480 grains of the iodide of potassium daily, freely diluted, of course, for some time before symptoms of iodism appeared. Then 60 grains were given three times daily for six months, when the bands of constriction were absorbed. To prevent any tendency of its returning, the patient was advised to continue the iodide in five-grain doses three times a day.

Dr. John Bartlett cited a case of general chronic bronchitis of fifty years' standing, complicated with asthma, occurring in a man 70 years of age. He was supposed to have had consumption this

length of time. Eight years ago he commenced treating him by administering eight grains of the iodide three times a day, and he has not omitted a single day to take the remedy. The old gentleman has grown fatter and stronger since, and his appetite has not been impaired, nor have the kidneys ceased to perform their normal function.

Dr. Robison closed by saying that Balfour does not give as large doses of the iodide on first commencing the treatment in these cases as he formerly did. Now he begins by giving 15 or 20 grains of the iodide of potassium three times a day, and if the pulse becomes quickened or the heart becomes irritable, the medicine is discontinued for awhile.

(*To be continued.*)

EDITORIAL DEPARTMENT.

PERISCOPE.

How to Prepare Antiseptic Dressings of Mercuric Bichloride.

Dr. Charles Meigs Wilson thus writes in the *Medical Times*, September 6, 1884:

Now that the advantages of the mercuric bichloride as an antiseptic dressing have been clearly established, receiving as it does the sanction of so many eminent surgical authorities, and becoming extensively employed in hospital and private practice, a few words as to its proper preparation for such purposes may be of interest. Corrosive sublimate is soluble in water in the proportion of thirty grains to the ounce. Various vehicles have been employed, as glycerine, ether, alcohol, or the latter in equal parts with water. Of all these the preference should be given to water as a medium, because of its capability of imbibition and solution, and the readiness with which it may be obtained. Sufficient sodium chloride should be added to solutions of the sublimate (an equal part) to prevent the latter's decomposition and the formation of calomel. In hospitals it is possible to have the solutions freshly prepared and frequently renewed, but in private practice this is not always feasible, especially if the case be of long duration and at a distance from a drug-shop. A convenient solution for private use, and one which will keep indefinitely, is the following:

℞. Hydrarg. bichlor.,	℥ ij.
Sodii chlorid.,	℥ j.
Aquæ destillat.,	f. ℥ iv.

M.

One fluidrachm of this, added to a pint of water makes a solution of about one to a thousand. Sir Joseph Lister* makes use of the following formula in preparing solutions of corrosive sublimate: One drachm by weight of a solution, one part of corrosive sublimate in one and one-half parts of glycerine, contains two-fifths its weight, or twenty-four grains, of the sublimate. This multiplied by one thousand (the proportion of water required) gives twenty-four thousand grains, or nearly three pints. It is, however, much more convenient to use fluid measure than weight, and one fluidrachm of the glycerine solution referred to requires four pints of water to produce the one to one thousand solution. Surgical authorities are pretty well agreed that one to one thousand is the proper solution to use for douching, washing, and dressing wounds. For vaginal or uterine irrigation, one to two thousand is the proper strength, and no stronger solution should be used in abdominal surgery. The best medium in which to use the corrosive sublimate for surgical dressings is finely-pulverized wood.† This may be obtained at a number of the instrument-makers' and drug-shops. The wood-wool is sterilized by being subjected to a dry heat (above 220° F.). It is then soaked for twelve hours in a one-half per cent. solution of corrosive sublimate; afterwards it is spread out and dried. It is then placed in a bag of gauze (such as is used for the Lister dressing) or mosquito-bar netting, prepared by being saturated with the following solution:

℞. Corrosive sublimate,	gr. x.
Alcohol,	f. ℥ ix. et f. ℥ ij.
Glycerin,	f. ℥ j. et ♏ xx.

This dressing is applied dry. Care should be taken to apply the dressing so that the margins of the bag extend an inch or so beyond the margins of the wound. This dressing is capable of absorbing twelve times its weight in water. It is applied with the ordinary roller, and requires no mackintosh or covering.

In cases in which there is a moderate amount of suppuration, this dressing may be left until the external dressing becomes soiled. The wood-wool prepared according to the above formula is the dressing which is almost exclusively used at St. Thomas's Hospital and many of the other London hospitals. The following formula I take from the report of St. Mary's General Hospital, Brooklyn, N. Y. Dissolve six grains of the corrosive sublimate in a half-ounce each of ether and alcohol. Dissolve twenty-four grains of the chloride of sodium (added to prevent the decomposition of the sublimate and formation of calomel) in an ounce of glycerin. Mix the two solutions, and triturate well with one pound of wood-wool; spread out to dry, and, after the ether and alcohol have evaporated, mix well with one part to ten by weight of powdered naphthaline. Thus prepared, we have a dressing that can be applied in a dry state, will absorb twelve times its own weight of water, is easily prepared, is simple, readily applied, and, above all, fulfills all the requirements of a true antiseptic dressing. The combination of these two agents gives us the most powerful germicide we know of—viz., corrosive

Brit. Med. Journal, May 24, 1884.

†This wood-wool may be obtained from M. R. Hopkins, 72 Duane street, New York.

sublimate—thus insuring a perfectly aseptic dressing, which, while it prevents any decomposition of the secretions of the wound, offers but a slight obstacle to germ-laden air, and the naphthaline constantly given off in a gaseous state by the heat of the body maintains a true antiseptic atmosphere around the wound. Naphthaline is non-poisonous, has established antiseptic properties, and appears to exert a specific influence over the contagion of erysipelas. The wood-wool prepared in this way is used as a dressing in precisely the same way as that prepared by the first formula. The indications for renewal are the same as those in any other form of antiseptic dressing. The simplicity of these dressings is their great charm, and renders them especially applicable for primary dressings. Equipped with a few bags of this dressing and a few roller bandages, the ambulance surgeon would be ready to place a wound, almost immediately after its occurrence, under antiseptic conditions. This is important in all cases, but especially so in cases of penetrating wounds, compound fractures, and other severe injuries.

The following precautions should be used in operations. Before the operation, the parts should be freely douched with $\frac{1}{1000}$ solution. An asepticized ligature (pure silk is preferable) should be used. All hemorrhage should be checked temporarily with the Billroth artery-forceps, until a ligature, if one is needed, can be applied. Before the wound is closed it should show no evidences of hemorrhage; and before the final stitches are placed *in situ*, the innermost recesses of the wound should be well *flooded* with the $\frac{1}{1000}$ solution. The same solution should be used to asepticize the sponges, and in the interim between operations they should be left to soak in a one per cent. solution. When it is desired to wash out the uterus, as in cases of puerperal septicæmia $\frac{1}{2000}$ is the proper strength to employ. In uterine irrigation the method by simple hydrostatic pressure should always be used, as otherwise there is danger of introducing air with the syringe.

As a disinfectant, corrosive sublimate is the best agent we have, because of its germicidic properties (which are unrivalled), because of its cheapness and the simplicity of its preparation, and, what is very important, it has no odor. A solution of bichloride of mercury for disinfecting purposes is readily made by mixing it with an equal part of common salt, and dissolving in water in the proportion of one gramme to one thousand cubic centimetres, or one ounce to eight gallons of water.* As far as the danger of mercurialism goes, in my own experience, embracing over four hundred cases, most of them severe cases, in hospitals in which no walking cases were admitted, I have seen only two cases of ptyalism, one in a negro woman aged 50, in whom the "dinner-plate" amputation of the right mamma had been performed. Her condition was miserable from the outset; and, after three weeks' continuous dressing with the $\frac{1}{1000}$ solution, pyæmia developed, attended with uncontrollable diarrhœa; at the same time there was marked increase of the salivary secretion, but no mercurial fetor, and no blueness of the gums. The other case was that of a hospital nurse, who, in order to get a holiday, simulated mercurialism; but careful investigation showed that he was feigning. These two cases I mention because some of the house-staff at the Pennsylvania Hospital, where they occurred, considered them as genuine cases of poisoning by the solution, though I believe that in reality they were not. At present the mercurial bichloride in the proportion of $\frac{1}{1000}$ is extensively used as an antiseptic in the Jefferson, Pennsylvania, and Blockley Hospitals in Philadelphia. Personally, I have used it in a large number of cases with the best results—among others, several cases of compound fractures, which did exceedingly well. In a recent number of the *Medical Record* I reported several cases of penetrating wounds of the abdomen, in which, though brought into direct contact with the perineum, no effects of mercurialism were observed, and the wounds healed promptly. It is to be hoped that some day it may be tried in a case of laparotomy. As a dressing, the sublimate has received the sanction of nearly all the Continental and English surgeons, among them that of the great apostle of asepsis, Sir Jos. Lister. In America it is even more extensively used.

* *Med. News*, August 2.

Treatment of Pelvic Hæmatocele.

This affection is so comparatively rarely met with that we are apt to become rusty in the treatment, hence it seems well to reproduce the following remarks of Dr. Alfred Wiltshire's from the *Lancet*, September 27, 1884:

As to the treatment of pelvic hæmatoceles, the cardinal injunction in most cases is absolute rest and opium. The value of opium is here transcendent. It tranquilizes, relieves pain, and enables the exhausted and collapsed patient better to bear the blood loss, while it compels repose, both mental and bodily. But to procure these desirable ends it must be given in full doses, and be repeated as may be necessary. The best method is to give it in one-grain doses of the solid opium, either in pill or powder. Next to solid opium, Battey's sedative solution of opium is good; but morphia is much less useful in these hemorrhages, especially in the cataclysmic forms. Ice and brandy, champagne, or other suitable stimulants may be requisite; and, above all, Valentine's meat-juice is most valuable. Peptonized meats and other foods (Benger's, Darby's, and others) may be useful adjuncts. In certain cases the hypodermic injection of ergotine of Tanret (Paris) may be helpful, and tincture of hamamelis may help in certain forms. The bladder should be relieved by catheterism with antiseptic precautions, as may be required. The use of astringents, such as gallic and other acids, is not great in these accidents, nor can I recommend the use of heavy bags of ice to the abdomen. But besides medical treatment, certain grave surgical questions arise in some cases, and demand urgent solution: for example, in cases where there are reasonable grounds for suspecting the source of internal hemorrhage to be a ruptured tubal or other pregnancy, and in similar accidents, such as bursting of a vein in the pampiniform plexus or elsewhere, where the diagnosis is sufficiently

clear; in short, in those cataclysmic intra-peritoneal bleedings where rapid dissolution is threatened, prompt operation may not only be justified, but become imperative to rescue the patient from impending death. It must not be forgotten, however, that even in ruptured ectopic gestations many patients recover without operation, as has happened several times within my own experience. The difficulty of accurate diagnosis is no doubt sometimes great, but not always; and when the well-balanced judgment arrives at reasonable grounds for belief that hemorrhage threatening to be rapidly fatal is going on unchecked from a controllable vascular lesion, then a bold, but not rash, interference is justifiable, and in these days of heroic abdominal surgery laparotomy should be done without delay.

During the later stages of pelvic hæmatoceles watchful supervision of the patient is necessary. The bladder should be carefully attended to with scrupulous cleanliness and great gentleness. Bed-sores should be prevented if possible. The bowels as a rule should be seldom opened. The mouth often becomes sore from the glazy and raw condition of the tongue and lips, therefore all food should be bland. Sedative mouth-washes give much relief (borax, myrrh, wine of opium, mucilages, and orange-flower or rose-water). The better patients are fed and cared for the sooner does the effusion disappear according to my experience. Care should be taken to guard against relapses or exacerbations, which are apt to occur about the time of the next catamenial period. I have been able occasionally to predict a fresh effusion at these epochs; and when such happens, it is followed by fresh manifestations of hæmatic jaundice. There is periodicity about these forms of hemorrhage, and the explanation of effusions occurring at the inter-menstrual or fortnightly periods is that it is part of a minor nisus that happens then. The condition of the vascular system will warn the physician, and the sphygmograph or finger may indicate increased arterial tension, while the eye can see the venous turgescence. Undue vascular excitement may be reduced by aconite, amyl-nitrite, nitro-glycerine, the bromides, etc. The pelvic viscera may be quieted by actæa racemosa, mono-bromide of camphor, Indian hemp, conium, gelsemine, and so on, given internally, and by vaginal pessaries of iodoform, conia, morphia, atropia, etc., or by rectal suppositories. An atmosphere of turpentine about the sick chamber is good, both for styptic and purifying influences. With reference to the puncture of hæmatoceles, I should, as a rule, deprecate opening, and would counsel caution in resorting to any operative measures. Should relief become necessary in the later stages from suspicion of suppuration or decomposition of blood, or from clear evidence of intolerable or dangerous tension, then aspirate by the vagina and not by the rectum; but operation is generally undesirable, and should be carefully resorted to. During convalescence sea air and water will be found beneficial, and where absorption is tardy poultices of scalded seaweed and brine baths are essential.

A Remarkable Case of Cough.

Dr. A. W. MacCoy reports this case in the *Med. News*, August 30, 1884:

Mrs. S., æt. 40, resident of Philadelphia, married twice, the mother of one healthy child, was first seen in December, 1882. At this time she was suffering from an almost continuous, exhausting, irritative cough, accompanied by violent fits of gagging, which had defied all treatment, and which had continued for several years. The patient was very thin of flesh, and her face much careworn. She stated that her attacks of cough often lasted for hours, and were frequently accompanied by the fits of gagging, which came on after the cough had continued for a short time. Sometimes after ascending the stairs gagging would follow, and soon render her helpless. Her debility was so marked after one of these paroxysms that she frequently had to go to bed, and was compelled to remain there for some hours. Between the attacks of coughing and gagging she was rendered most miserable, and was completely debarred from social engagements.

Examination showed no pulmonary disease. Inspection of fauces revealed marked cicatrices, involving most of the posterior pharyngeal wall, extending well down the throat. Laryngoscopic examination at once made manifest the cause of her attacks. On a line with the superior margin of the arytenoidal portion of the larynx, on the posterior wall of the pharynx, was a horizontal cicatricial band extending well across the pharynx, about one-eighth of an inch in diameter, the ends of which spread out in a fan-shaped manner, the fibres being lost in the tissues on each side. This band was so placed that the free edge of the epiglottis was touched by it while rising and falling, and readily explained the cause of the cough. The gagging was brought about by interference with the free action of the vertical and circular muscular fibres of the pharynx, as well as by impingement of the free edge of the epiglottis.

The *specific* action (undoubtedly the cause of the destructive change) had long since ceased. While there was no direct history of syphilis, there was a history of a severe attack of ulcerative disease many years before, which she states her physician called diphtheria. No lesions of syphilis excepting those found in the throat were visible.

The treatment consisted in dividing the cicatricial band with the galvano-cautery knife *vertically*, and dilatation. The first operation was not attended by perfect success, owing to the incision being too near the median line. A few weeks after the first operation a second incision was made on the left side, much longer and deeper than the first one. This effort was eminently successful. For six months there was absolutely no return of cough and gagging. Quite recently there has been some return of her attacks from neglect to keep up the dilatation. Another operation of multiple incisions was made a few months ago, which again completely relieved her. With occasional dilatation it is probable that the result will be perfect, but without it contraction will certainly occur in time (as is so well known), and the result will not be so satisfactory as it now is.

The adaptability of the galvano-cautery knife for the relief of this condition has so impressed me that I am unable to see how the operation

could have been performed so safely and so well by any other method.

Urethral Ectasia.

Dr. C. C. Fite reports this case in the *Jour. Am. Med. Ass.*, August 30, 1884:

"I had been engaged to treat Mollie H., for what she designated 'womb disease,' and in making the necessary examination to ascertain the position and condition of the parts, I made the following discovery. In passing the finger, a tumor was felt just under the urethral orifice, and she said at once, 'There it is, that is the trouble: it don't hurt much to pass it or to have intercourse, but it pains me in walking and when I make water, and sometimes it takes a long time to pass it, and occasionally it dribbles away of itself.'

"Upon more careful inquiry, she admitted that coitus was painful unless they were careful, but as she was very fond of that amusement, she tried to make no complaint.

"She is a muscular, ordinarily healthy white woman, 24 years of age; married at 15, has had two children, one born ten months after marriage, and the second in thirteen months from the first; has miscarried twice, about the third month, since that time. She had difficult labor with both children, but got through without instrumental interference. After the second birth she says she had 'inflammation of the womb, and of the bladder, and the milk dried up.'

"There is no history of any other severe illness or disease of any kind.

"She had been instructed to retain her urine for some hours before the examination, as I find it sometimes of value to examine with a full bladder, and then after it is emptied. A silver catheter was passed, and went readily into the bladder, and on being partially withdrawn the point was turned down, and the nature of the trouble was clearly demonstrated. The catheter was again passed to the bladder, and the contents withdrawn. When the instrument was being released from the meatus she complained of a sharp burning pain which lasted some minutes; she said that it always pained her so after urination.

"I was satisfied at once of the nature of the case, and explained that the uterus needed no special treatment (having used a modification of the Sims speculum, and completed the usual explorations and found only a slightly enlarged and heavy organ), and advised an operation to reduce the size of the distended canal.

"She was opposed to this, and would not consent to operative measures, but was 'willing to have medicine put on it,' so I made three applications a week apart, of a 20-gr. solution of nit. silver, to the relaxed membranes covering the sacky canal.

"After the applications the vagina and vulva were packed with absorbent cotton, which was retained six hours. I also ordered injections of claret and tannin, ℈j. to f. ℥viij., twice daily. She reported herself as well two weeks after the last application; but as she is now living elsewhere I have not been able to verify the statement, I explained to her that the cure was likely to be only temporary, and that an operation would doubtless be yet needed, as the dilated canal had only been braced up and not organically reduced to its normal size. The trouble dated from the second labor, and I suppose the protracted pressure of the fœtal head against the urethra must have caused the relaxation of its fibre.

Rheumatic Periostitis.

From the *Lancet*, September 27, 1884, we learn that a discussion took place at a recent meeting of the French Association for the Advancement of Science, held at Blois, on a communication by M. Verneuil, entitled "Ephemeral Rheumatic Periostitis," an affection which has not attracted a large share of attention from writers on medicine. It is described by M. Verneuil as appearing in the form of a hard swelling, becoming softer after the lapse of a certain time. Fluctuation, which is sometimes present, leads to suggestion of pus; but this phenomenon disappears and the swelling subsides. There is no hyperplasia like that seen in ordinary surgical periostitis, no fever, and no alteration in the color of the skin. In some places the affection spontaneously disappears, in others the swelling first diminishes and then increases in size; there seems to be a congestive element in the swelling, for "when the patient took cold" one of the swellings on the face became double its former size. In none of the cases was there evidence of antecedent syphilis, though the arthritic diathesis was well represented. Many observers who spoke on M. Verneuil's paper had witnessed similar affections. On purely theoretical grounds there does not appear to be any argument against the occurrence of rheumatic nodes or periostitis. We have nothing to do in this occasion with the "subcutaneous rheumatic nodules" so well worked at by Drs. Barlow, Warner, and others. We may also take it for granted that the periostitis was not confounded with the nodose erythemata of rheumatism, where the skin is the site involved. Physicians of large experience cannot fail to have seen examples of periostitis occurring in rheumatic cases. We have no wish to beg the question; and it is right that the whole evidence on which the rheumatic origin of such cases of periostitis exist should be placed clearly before us. In our experience there has been distinct affection of joints of typical rheumatic nature with sweating, and in some instances heart affection and fugitive erythemata with fever of moderate degree. In one case which we recall, the tonsil was also inflamed, whilst there was mitral disease of some standing, distinct affection of both knees and the right wrist, with periostitis of the lower third of the inner side of the right tibia, occurring in a man aged twenty-four, in whom no evidence of syphilis could be elicited, and who was not suffering from gonorrhœa. We should be chary of admitting the presence of rheumatic periostitis when no other "rheumatic" manifestations are to be found. We may also state that in our experience nothing we should call fluctuation was detected. The subject is one well worthy of extensive investigation, and would undoubtedly add to our knowledge of that most protean and most ill-understood affection—rheumatism.

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D. G. BRINTON, M. D.,
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THE TREATMENT OF CHOLERA IN TOULON.

In the hospitals as well as in private practice in Toulon, cholera patients are at present treated as follows (*Bull. gén. de Thérap.*, September 1884). All cholera patients are subjected to a definite medical treatment, according to the severity of the disease, and the latter is subdivided for this purpose into:

1. The cholera-diarrhœa or mild cholera.
2. The medium-grave form, and
3. Grave cholera.

1. The *mild* form is especially treated with opium. Clysmata of amylum, to which opium is added, are also used. Internally the following formula seems to be most in vogue:

℞.	Æther. sulph.,	♏ xvj.
	Tinct. opii deod.,	♏ xv. usque ad xx.
	Ext. rhatany,	gr. xvj.
	Sy. aurant. cortic.,	f. ℥j.
	Aquæ melissæ,	ad f. ℥v.

Vomiting is best stopped by a dessert-spoonful of Chartreuse every fifteen minutes, followed by a piece of ice. Occasionally vomiting and diarrhœa are successfully subdued by magist. bismuthi, either alone or combined with opium; and in case of cramps in the stomach castor oil is generally administered. When vomiting or diarrhœa has ceased, but some sensitiveness and soreness of the stomach remains, tinct. columbo, with wine, forms the most favorite remedy. Many cases under this treatment passed over into the graver forms, but they all rapidly recovered, when the following medicine was administered:

℞.	Acid sulphur. dilut.,	f. ℥ss.
	Tinct. ferri chlorid.,	f℥.iij.
	Tinct. cardam comp.,	f℥.v.
	Syrup zingiberis,	f. ℥iij.
	Aquæ morphiæ,	f. ℥iss.

M. S.—A tablespoonful every two hours; after the cessation of diarrhœa and vomiting the dose was gradually diminished and given at longer intervals.

The *medium-grave* form is treated in the beginning as the one just mentioned (before employment of acids), but the utility of lavements with warm wine and some drops of laudanum, has been acknowledged; they also act later as exciting means. Carbonic acid drinks cooled in ice, influence the vomiting favorably. In numerous cases Dujardin-Beaumetz's recommendation—

water saturated with oxygen—has been tried—generally in vain. The spasms yielded mostly to dry frictions with flannel, or to the employment of spirit. camphoræ, opodeldoc, terebinthina and chloroform. Spasm of the diaphragm and præcordial anxiety at once disappeared upon a hypodermic injection of morphia in the epigastric region. Later, the success was still greater, when to a sixth of a grain of muriate of morphia one hundredth of a grain of atropia was added. In case the spasms in the extremities, but especially those of the calves, did not yield to these remedies, subcutaneous injections of ether into the contracted muscles caused their disappearance. And if these too failed, the treatment of the *Grave* form was instituted. Grave cholera presents itself in two varieties, the asphyxic or algid and the non-asphyxic.

In the asphyxic form, the patient's body is ice-cold; his face cyanotic. The main point is here to stimulate the heart's action and keep up the bodily temperature. For this purpose, injections of ether (up to one syringeful every hour) were made, but only in very few cases was life prolonged for 24 hours. Opium and morphine evinced here a deleterious effect, the asphyxic symptoms augmenting still more. On the other hand, hypodermic injections of sulphate of atropia were of decided benefit—generally the $\frac{1}{120}$ grain of atropia was injected from four to five times within 24 hours; the action of the heart became stronger, the pulse could be felt, and the temperature increased, but it must be mentioned that other stimulants, as hot punch, Chartreuse, ether, aqua ammoniæ, etc., were not neglected, but administered at the same time. Occasionally persons, already dying, were for some hours once more brought back to life by faradization near to the subclavia. Further experiments were made, especially by Dr. Cunco, with the inhalation of pure oxygen by aid of a mask or through the nose with a tube. These inhalations were usually practiced for two to three minutes every hour or two. Six patients, who had been declared doomed, are said in this way to have been saved, and it is the opinion of Dr. Cunco that these inhalations are destined to play an important role in the treatment at least of the asphyxic form, while they are useless in the non-asphyxic variety, in which the body still retains some warmth, and in which neither cyanosis nor coldness are prominent symptoms.

In the non-asphyxic form the patient has a face the color of death, the nails are blue, but there may be felt a certain amount of bodily heat, and the pulse is small but perceptible to the very last moment. It is especially in this variety that the favorable prognosis of the physician is so often contradicted by what follows, for these patients, after they have fortunately passed through cholera, and are apparently recovering, suddenly lapse into a typhoid condition, to which they finally succumb.

During the cholera-typhoid, sulphate of quinine and valerian in conjunction with the cold douche and irritants applied to the skin, were frequently successful.

Dr. Cunco reports that of 68 medium-grave and grave cases but 16 died, and of these 10 belonged to the non-asphyxic variety.

While the treatment contains really nothing new and a great deal that is obsolete and evidently useless or only a placebo, the observation alone that cases of the non-asphyxic variety, after having escaped all danger from the attack, fall into a typhoid state, in which they are apt to die, is of sufficient importance to warrant the publication of the foregoing statements.

Dr. Larrivé (*Journ. de Méd. de Paris*, vol. vii., No. 7, Société de Médecine Practique) is of the opinion that the administration of large quantities of water, which has been saturated with oxygen is the most radical treatment. The above report shows its uselessness; besides, it seems to us, as if in case of a want of water in a kitchen, due to bursting of a pipe in the ground, the evil could be remedied by pumping larger quantities of the same fluid into the reservoir from which the pipe draws the water supply. Just as ridiculous it appears to us to remedy the abstraction of oxygen and the watery portion of the blood by the introduction of both into the system, for the

effect can be but a greater supply of products to be wasted.

ONE OF THE CAUSES OF NIGHTMARE.

Especially older persons are frequently suffering from restlessness at night due to nightmare. Rheumatic and gouty individuals seem to complain oftener of this disturbance of their sleep than others. Generally increase of arterial pressure or venous stasis in the circulation of the brain is mentioned as a pathogenic cause, and the patient accordingly treated. Rarely a careful examination is made, and a case, reported by Dr. Th. Clemens, of Frankfurt-on-Main (*Aug. Med. Central Zeit.*, Sept. 3, 1884), may, therefore, be specially interesting, and at the same time highly instructive.

H. C., æt. 58, consulted C. on account of gradually increasing nightmare, which troubled him during sleep. The patient, suffering from gouty symptom, had for years been the victim of heavy dreams. For the last few months these dreams have, however, assumed the character of nightmare, and been so disagreeable as to produce in the patient a dread of going to bed. His wife, who sleeps in the same room, describes the condition of her husband during the night as a deep, anxious moaning, which, if the patient is loudly spoken to and shaken, ends in a loud, inarticulate cry—a genuine nightmare, therefore. The next morning after such a night, the patient feels feeble and complains of a general lassitude, and the condition of his mind during such a forenoon is called by himself, a melancholic one. These attacks, happening without any apparent reason, and even when the supper had consisted of the blandest diet, usually set in from three to four times a week, and many different remedies for it have been tried in vain. The patient inquired of the doctor, whether electricity might not relieve him of these annoying seizures. The physical examination of the very robust patient indicated an impulse of the heart rather feeble, considering his vigorous build, without awakening the suspicion of a fatty heart, as nowhere an increase of adipose tissue could be noted. Several mornings after such a night of dread, the urine has been found to contain albumen. The patient, a very thirsty individual, used a great deal of soda-water, beer, and cider, and lived well, without leading a specially unreasonable existence. As there seemed to be very little tendency to perspiration, the quantity of the urine was augmented, but with the occasional exception noted, no albumen or sugar was found, though the reaction was very acid. No organic lesion was to be discovered, nor could the morbid symptoms be attributed to any depressing mental influence. Supposing that the action of the heart already being feeble—probably in consequence of its diminished excitation by the gouty blood—a stasis in the blood, no matter how produced accidentally, might thus impede it, and cause these attacks, C. ordered climbing mountains and dry diet. After three o'clock in the afternoon the patient was not permitted to drink a drop of any fluid; for supper he was advised to take salad with plenty of vinegar, cold meat, and toasted white bread. Within one week the nightmare ceased to recur; albumen was no longer detected in the morning urine, and the patient recovered his general health, and lost his dread of going to bed at night.

While the above case is doubtless an interesting one, we cannot see how the treatment adopted, no matter how successful, agrees with the diagnosis of the case. It seems to us as if this way of reasoning is very similar to the one which recommends as a radical cure of dropsy the withdrawal of all fluid diet.

OUR SEWERS.

A bill is now before councils in this city, to create a commission for the purpose of overhauling our sewerage system, and our Board of Health has passed a resolution asking councils to create this commission. "Let us make haste slowly." In truth, to-day, we would be better off if we had no sewers in this city, so abominably faulty is everything connected with them. We most earnestly protest against any "patching up" of our present system, for it is radically wrong. We have

said so much about drainage and sewerage, that it seems almost tiresome to write again on the subject; but it is our duty at this moment, when the question is under consideration by our municipal authorities, to offer some suggestions on the subject.

It is very generally admitted by sanitarians that the proper and most approved method of disposing of sewage, of human refuse, is by *irrigation*, using the word not so much literally, as in its broader sense of returning to the soil that which we have taken from it. This method of sewage disposal has been demonstrated to be both practicable and profitable, on a large scale in Europe, and on a smaller scale in our own country. That human refuse can be converted into excellent manure, and that it pays so to utilize it, has been abundantly demonstrated, and it has been conclusively proven that it is the best means of solving the problem of the "removal of waste."

To so utilize the sewage of a large city like Philadelphia, would, of course, entail a large original outlay of money, but it would *pay*. Our taxpayers have submitted to the unnecessary expenditure of millions upon a building that will produce no revenue to the city; hence we are very confident that they would not object to a similar outlay for an improvement that is not only obviously essential to their welfare and happiness, but that would surely produce a large revenue. We have already noted the fact that something like $2,000,000 worth of ammonia goes annually to waste in this city in the urine passed by its inhabitants; and this is but a fraction of the valuable organic refuse that is every year not only wasted, but worse, is made to poison our bodies and deprave our health, owing to its faulty and incomplete removal.

Such a system of sewers as we possess can never be made to satisfactorily accomplish their intended purpose. They may be numerous, properly graded, ventilated, and cemented, so that all the refuse may be conducted through them; but the result, as we have time and again pointed out, will be that in time the rivers that bind us, will become uncovered sewers, constantly giving off foul emanations to be wafted by the winds into the palaces of the rich and the hovels of the poor. No, we must realize that there is but one way of rendering our refuse harmless, and that is, to repeat, to convert it into manure. Both from a sanitary and an economical point of view, this method must commend itself. If we have too much debt, and our officials fear that the taxpayers will not stand any extra demands, let us wait until the White Elephant at Broad and Market is completed, and then, without any heavier tax than at present, we can divert these millions into the channel of sewerage reform.

A SUBSTANTIAL AND MERITED TESTIMONIAL.

We take much pleasure in laying the following correspondence before our readers. It is a proof that if a low and unreasoning prejudice does at times crystallize itself into an attack on science, even if this prejudice is abetted for selfish reasons by those who should be the first to oppose it, yet the sympathy of the profession is on the right side and is ready to show itself by both act and word.

We may add for the information of those readers not acquainted with the circumstances that Dr. FORBES was prosecuted while Demonstrator of Anatomy of the Jefferson Medical College for alleged violation of the cemetery acts of this State. After an expensive trial, towards which the college rendered him no assistance, he was triumphantly acquitted. The profession at large then took up the matter as one meriting substantial proof of wide sympathy with the result indicated below:

222 SOUTH 16TH ST., PHILA.,
August 1, 1884.

DEAR DR. FORBES: I enclose, with the approval of Drs. AGNEW and LEVIS, a check for $1,500, which represents the fund contributed by the profession towards the expenses to which you were recently so unfortunately put. It represents also, I am sure, a great deal of hearty sympathy and sincere respect which, I know, are of more value to you than the money itself. With best wishes and warm regards believe me

Yours faithfully,
J. WILLIAM WHITE.

PHILADELPHIA, August, 2, 1884.

DEAR DR. WHITE: I received to-day your letter of yesterday enclosing, with the approval of Drs. Agnew and

Levis, a check for $1,500. You state that this check represents the fund which was contributed by the profession towards the expense to which I have been recently so unfortunately put, and that it likewise represents a great deal of hearty sympathy and sincere respect for me on the part of the profession at large.

It is exceedingly gratifying to me to be thus made aware of the feeling in the profession in so pronounced a manner. It emphasizes the verdict of the court and of the public at large, as expressed in the daily papers and in the medical journals.

I beg to make my grateful acknowledgments at the receipt of this marked expression of professional feeling and approbation at my conduct while in the line of my duty.

Very respectfully yours,

WM. S. FORBES, M. D.,

Demonstrator of Anatomy, Jefferson Medical College.

NOTES AND COMMENTS.

The Therapeutics of Continuous Inhalation.

The Messrs. Wyeth & Bro., of this city, now make and sell an apparatus for the continuous inhalation of volatile medicaments. The suggestion was first made some two years ago by Dr. I. Burney Yeo, of London, and the instrument offered by the Wyeths is a modification by Dr. J. Solis Cohen of that devised by Dr. Yeo. Roughly speaking, it is an apparatus that fits over the nose and mouth, and contains a sponge on which the drug to be used is poured. Dr. S. Solis Cohen and his brother (J. Solis) have been making some observations with this method for the past two years, and from their results published in the *Medical News*, October 11, 1884, we note the following points:

In Phthisis.—The inhalation of terebene (ten drops, renewed every second or third hour) as continuously as possible during the day, with the addition of chloroform (five drops at bed-time) during the night has seemed to give much comfort. Where there was marked laryngeal disease, creasote acted better, while when there was extreme ulceration, eucalyptus acted better than either.

Of course, these drugs were not *curative* in any sense, but only palliative.

In bronchitis good results were obtained from inhalations (an hour or two at a time) of terebene, turpentine, or tincture of benzoin. In profuse bronchorrhœa, ethyl iodide has acted well. It has also acted well in *pleurisy*, *chronic laryngitis* and *tracheitis*, *nasal catarrh* (using creasote).

In Syphilitic Disease of the Throat, of the Nose, and of the Ear.—In cases of syphilitic laryngitis, and in a few cases of syphilitic rhinitis, one of the latter being marked by profuse fetid discharges both anteriorly and posteriorly with involvement of the middle ear. Curative results have been obtained by the administration of ethyl iodide by continuous inhalation from the Yeo respirator. In cases of extensive or rapidly spreading ulceration, however, exclusive reliance has not been placed upon this method of treatment.

In Pertussis.—Some amelioration has seemed to be produced by the inhalation of tincture of thymol, eucalyptol, tincture of benzoin, creasote, and chloroform in pertussis; but while the relief has been marked in a few instances, the results have not on the whole been very satisfactory.

In Hay Fever and Asthma.—Trial of the method is being made in hay fever and in asthma, but as yet, no conclusion can be drawn.

Scarlet Fever in a Canary.

Since the question has been somewhat discussed as to whether it is possible for the zymotic diseases to be transmitted from man to the lower animals, the following case (in his own words) which Dr. Frank Ogston reports in the *Brit. Med. Jour.*, September 27, 1884, will be interesting:

"A few months ago, while attending a family in which scarlet fever had attacked two children, my attention was called to a cage containing four young canaries. I remarked that they seemed ill, as they were sitting moping on their perches, with their feathers ruffled up. The mother of the children said to me, 'Doctor, I think they have gotten the fever. The grandmother (who had undertaken the nursing of the children) gave them some bread which the children had been eating.' The children were then desquamating freely.

"Two days afterwards, when seeing the children, I found the canaries quite well and lively, all but one, which drooped more than before, and now could hardly stand. On examining the bird, its skin, under the feathers, was of a bright scarlet color, unlike that of the others, which was of a yellow color, like old parchment. It died the following day, after making efforts to swallow, as if its throat had been painful and swollen.

"On inquiring why this one should have suffered so much, and the others so slightly, I was told that it had eaten greedily of the bread left by the children, which the others had hardly touched, and that it had pecked away some of the

loose epidermis from the lips of one of the children.

"It certainly seemed to me that the bird had scarlet fever; and it at least should give us the caution that our domestic pets may not only spread this disease by conveying the infected epidermal scales on their fur or feathers, but also by taking infection from their owners, and directly infecting individuals of the human species in their turn."

Calabash-Tree Fruit.

From the *Pharmaceutical Journal* we learn that Dr. Peckolt, of Rio Janeiro, who has contributed so much to the history of South American plants, has published a communication upon the fruit of the "calabash tree" (Crescentia cujete, L.) The plant is generally supposed to have been introduced into America from Africa by negroes; but Dr. Peckolt says that the Portuguese found it in America on their arrival. At any rate, it has long been utilized by the natives for economical and medicinal purposes. The flesh of the barely ripe fruit and the expressed juice of the fruit are popularly esteemed as medicines, and Dr. Peckolt confirms the estimate of the latter as a laxative. An alcoholic extract, in doses of .10 gramme, had the effect of a mild aperient, and the quantity could be increased to .5 gramme, which exercised a strong drastic action without griping or ill effects. As an application against erysipelas, the fresh pulp is boiled with water until it forms a black paste, to which vinegar is added and the whole boiled together, after which it is spread upon linen. A chemical examination of the fresh fruit pulp yielded a new organic acid, crystallizing in plates, to which the name "crescentic acid" has been given. It was obtained by exhausting with water an alcoholic extract of the pulp, heating the aqueous solution with lead acetate, suspending the lead precipitate in water, and decomposing and removing the lead, then evaporating the solution to a syrupy consistence, and leaving it to crystallize in a cool place. Besides crescentic acid, there were found tartaric acid, citric, and tannic acids, two resins, a bitter, and an aromatic extractive substance, and a coloring matter that appeared to resemble indigo.

Epileptiform Tic Cured by Nitro-Glycerine.

Dr. James P. Bramwell reports this case in the *Brit. Med. Jour.*, September 27, 1884:

The patient was 80 years of age, and enjoyed good health till nine months ago, when he was attacked by the disease in question. I shall give the history of the case in the patient's own words:

"Nine months ago, I was seized with pain in the back of the head, which came round by the joint of the jaw-bone on the right side, then spread over the face, chiefly the right cheek and temple. The muscles of my jaw were then fixed; to open my mouth was impossible. Any attempt to take food brought on a paroxysm of this kind. These turns lasted from five to six minutes, and went on without intermission for five months. The attacks came on sometimes as often as twelve times in the twenty-four hours; during the night they were oftener and more violent, my head being often pulled back with violence. I could not wash my face without bringing on a paroxysm, and a touch of my finger, a puff of cold air, or even a mental emotion, produced the same effect. Things went from bad to worse. I then called in Dr. Bramwell, who prescribed for me bromide of potassium and croton chloral-hydrate, but only with partial relief. Solution of nitroglycerine (0.1 per cent.) was given in drop-doses three times a day. The effect of this was almost immediate, and in four days all my morbid symptoms had gone. I have since then been four months in perfect health; there has been no return of the fits."

I publish this case in the hope that, in nitroglycerine, we may possibly possess a remedy for a malady which embitters life, and is indeed often quite intractable. I am fully aware what good results have accrued from nerve-stretching, or even the removal of Meckel's ganglion; but, before resorting to this somewhat formidable measure, it might be well to see if the use of the nitroglycerine might not obviate such a necessity.

A Cockle-burr in the Windpipe.

In the *American Practitioner*, October, 1884, Dr. J. N Outen reports the following rather instructive case:

"In 1854, a boy, aged seventeen, while cutting corn-stalks in a field, made the, to him, pleasing discovery that he could whistle through his windpipe while keeping his mouth open. He was practicing his new accomplishment as he pursued his work, when a cockle-burr was knocked into his larynx by a lick from his hoe. The usual symptoms instantly followed. A physician saw him the next morning, but for some reason made no effert to remove the burr. Some hours after the patient was brought to me. Thinking the foreign body might have lodged just under the epiglottis, I introduced my finger down to that point, and became at once satisfied that I had touched the burr with the tip of my nail. The

manouvre cut off what little air the boy had been getting, and he sank seemingly lifeless to the floor. When he sufficiently recovered his breath, I repeated my exploration, with the result this time of giving the burr a lucky turn and fortunately causing it to be expelled. Almost immediately after the patient could speak in a whisper. He soon regained his full voice, and was well.

Iron Alum in Uterine Hemorrhage.

The late Dr. Richard Richardson read a paper on uterine hemorrhage before the late meeting of the British Medical Association, in which he strongly recommends iron alum applied in crystals the size of a hazel-nut, or even larger in very severe cases. It is to be introduced with the finger up to the os uteri (and not into it) and there allowed to remain. The uterus will at once contract, a firm coagulum is formed, and the hemorrhage at once ceases. Iron alum is also antiseptic.

In *post-partum* hemorrhage it is advisable always to clear the uterus of clots or any portion of placenta before applying the crystal; also, in accidental hemorrhage, when there is detachment of placenta, should the case appear to be one where there is no chance of carrying it to full term, the membranes ought to be punctured, and the iron alum applied in the usual way. There is no fear of any great hemorrhage coming on afterwards; in a slight case, the iron alum will stop it; but, if the hemorrhage should recur, it would be advisable to puncture the membranes, and induce labor.

Cholera in the Lower Animals.

The *London Medical Times*, September 20, 1884, tells us that at last success has attended the efforts to convey cholera to animals. Drs. Nicati and Rietsch, inspired by Dr. Koch's example and advice, collected masses of the cholera microbe from the intestines of patients who had just died of the disease, and inoculated some dogs and guinea-pigs with them. All the animals operated on were seized with cholera, and died, the guinea pigs within 48 hours, the dogs within four days. Other experiments were made with regard to the influence of the gastric juice and the bile on the growth of the microbes, which it was found were destroyed by both these secretions. It is suggested that a certain means of diagnosis in a suspected case of cholera is provided by the injection of the stools of such a case into the duodenum of a guinea-pig, which will forthwith if the case is one of true cholera, succumb to the disease. We are not told, however, whether the injection of a simple diarrhœa stool, under the same circumstances, may not be attended by a like result. The experiments as well as the conclusions of Drs. Nicati and Rietsch will, no doubt, be subjected to the sharpest scrutiny.

How to Administer a Hypodermic.

Although seemingly a simple matter, yet we have seen many physicians go about the administration of a hypodermic in a bungling way. Hence we gladly reproduce the following directions by Dr. Q. C. Smith, in the *Texas Courier-Record of Medicine* for September. In order that his directions may be carried out, it is necessary that the point of the needle should be both sharp and clean, conditions that are not always found.

"Let the operator with his left hand grasp the patient's arm from the side opposite that into which the injection is to be made, and draw the skin very taut, and with the right hand hold the syringe firmly, pointed almost at a right angle to the arm, and with a short, quick, decisive movement, thrust the needle through the skin and well into the *muscular* tissue; then gently relax the grasp of the left hand, but continue to steadily support the arm; then slowly drive the piston home, then remove the syringe with a quick, decisive, straight movement. This mode of administering hypodermics reduces the pain and liability to abscess attendant upon the operation, to a minimum, and is far preferable to the mode usually recommended and practiced."

Chloroform and Croton Oil for Tape Worm.

The experience of Dr. Bernard Persh, a hospital steward in the United States army, was not unique, when he tried and failed with nearly every remedy that has ever been recommended to remove tape worm. Finally, some one suggested to him the use of chloroform and croton oil, which removed his own tape worm in less than an hour. He has since given, or seen it given, to twenty cases, with most satisfactory results. He suspends one drop of croton oil and a drachm of chloroform in one ounce of glycerine; this to constitute one dose. The medicine is best given in the morning before breakfast, and no preparatory treatment is required, except half an ounce of Rochelle salt on the evening preceding the removal. The preliminary laxative is not necessary to effect a cure, and it was omitted in several cases; but its administration facilitates the examination of

the evacuations, prevents breaking up the worm by hard feces, and allows the parasite to pass more quickly through the intestines after becoming detached. The medicine is not unpleasant to take, and acts quickly. If any intestinal irritation is caused, it may be controlled with bismuth and opium after the expulsion of the worm.

Intra-Capsular Fracture of the Femur.

Dr. W. M. Fuqua is of the opinion that the "do nothing" plan of the older surgeons, in these cases, is wrong, and should be abandoned. Experience has shown that bony union can be had, and he thinks that every effort should be made to bring it about. He is satisfied that many of these fractures are through the inter-trochanteric lines, and therefore amenable to the reproductive influence of the periosteum. In the *American Practitioner* for October, 1884, he relates a case where, after ten or fifteen days' confinement to bed, he adjusted a well-fitting "*Sayre's short splint*," and placed the patient on his feet, having first lengthened the sound leg by the addition of an inch cork sole. With this appliance, and a crutch and cane, the patient walks about just as in a case of chronic disease of the coxo-femoral articulation. If the tendency to eversion, or possibly to inversion, be great, then "*Sayre's long splint*" would be required, night extension to be made by weight, and the splint to be used during the day.

Salicylate of Atropine.

From the *Lancet*, September 27, 1884, we learn that salicylate of atropine appears to be in some quarters displacing the sulphate. Herr Frederici has prepared the neutral salt by dissolving the atropine (twenty-three parts) with the aid of gentle heat in a suitable quantity of pure alcohol, and then adding the salicylic acid gradually to complete neutralization (eighteen parts) the solution being carefully tested with litmus paper during the operation. The liquid is then evaporated in a water-bath to a gelatinous consistence, the mass assuming an amber color, and the drying is finished in a sand-bath or drying-closet. The compound deliquesces quickly when exposed to the atmosphere, but is said to keep well if properly preserved, though the solution is very unstable.

Antiseptic Inhalations.

The question of antiseptic inhalations in pulmonary affections has had its advocates and those who condemn it, but whether they have any particular effect or not, there can be little question that Dr. Ward Cousins is right when he says in the *London Med. Times*, September 20, 1884, that apart altogether from any specific effect of the antiseptic vapors, it must be admitted that the act of continuous inhalation exerts a very salutary influence by stimulating full and repeated expansion of the lungs, and the forced activity of these organs is in itself an important factor of the treatment. The value of free inspiration, and the part it plays in the successful application of antiseptic inhalation has scarcely received the general recognition to which it is justly entitled.

Fluoride of Quinine for Enlarged Spleen.

Fluoride of quinine has recently been recommended by Dr. Weddell, of Calcutta, in the treatment of enlarged spleen. He has investigated the action of fluoric acid and the fluorides, and has come to the conclusion that in cases of chronically enlarged spleens of malarial origin the effects obtained are often very striking. In very small doses the fluorides have produced marked benefit in cases of rickets and other diseases associated with malnutrition of the osseous system. Of the salts of fluoric acid, Dr. Weddell considers those of quinine or quinetum (*i. e.*, of the mixed cinchona alkaloids) to be the best.

Phellandria.

In England this ancient remedy has received fresh attention, and is said to be a most valuable agent in treating various affections of the chest characterized by excessive cough, whether dry or attended with expectoration. Its action appears to be of a sedative as well as of an alterative and strengthening kind. Narcotism is not produced by its administration. It appears to have a special action against pulmonary phthisis. The most acceptable preparation is the syrup of phellandria used in a concentrated form. Other preparations, such as the arseniate of iron may be advantageously prescribed with the syrup.

The Phosphates in Alcoholism and Opiism.

Our correspondent, Dr. T. D. Crothers, of Hartford, Conn., has been comparing the effects of Horsford's Acid Phosphate with the acid phosphoric U. S. P. in cases of the above disorder. Though his study is incomplete, he thinks the acid phosphate the superior remedy both in building up functional energy and brain-force, and in restoring the nutritive forces of the body to a condition of normal activity.

CORRESPONDENCE.

Electricity.

EDS. MED. AND SURG. REPORTER:—

Dr. G. B. Massey, who was last year lecturer at the Med. Chirurgical College, must know how I came, as Professor of Nervous Diseases, to lecture during the preliminary course on electro-therapeutics. But three hours were at my disposal, during which to exhaust the subject of medical electricity. This limitation of time necessitated my being concise, otherwise I would have given an exhaustive explanation to most of my statements, and saved myself the trouble to have now to add special instructions for the sole benefit of my friend, Dr. M., who by his remarks on my lecture evidently requests or needs this enlightenment. I shall take up the different subjects in the same order as he mentions them.

One who has read the whole of my lecture with but slight attention, if conversant with electro-therapeutics, will at once see that in the passage, "In a galvanic pair the two contrary electricities have no difficulty in uniting through the intermediate fluid, but they, therefore, possess no great force or intensity," a *lapsus linguæ* occurred—instead of *intensity*, *tension* being meant. I shall show below that another statement in my lecture clearly proves this fact.

If Dr. M. contends, "that in a galvanic pair the two contrary electricities *do* have difficulty in uniting through the intermediate fluid," he must have forgotten that later on I also recognize the essential resistance, and that the statement quoted "that they have no difficulty," etc., refers simply to the difference noted in this respect between static and dynamic electricity. As I can not enter here into a full explanation, I will do the same with Dr. M. as I did with the students, viz: I refer here to "A Treatise on Medical Electricity," by J. Althaus, probably acknowledged by Dr. M. as an authority on the subject. In the third American edition (Phil., Lindsay & Blakiston, 1873), page 22, 16th line from below, he will find the words:

"In a galvanic pair the two contrary electricities have no difficulty in reuniting through the intermediate fluid."

Dr. M. next insists upon explicit information regarding my statement: "that increased resistance is needed to gain cautery power." From my article he must know my use of the term "resistance," and while I am willing to give him privately any instruction in my power with reference to the galvano-cautery, here, for want of space, I must once more ask him to consult the author previously quoted; page 51, 12th line from below, Althaus says:

"On the other hand, totally different arrangements must be made for using the galvanic cautery. *There it is necessary to increase the resistance*, and we, therefore, use" * * * Dr. M. will also find there the explanation he needs.

The sense in which I employ the English word "force" in connection with another remark of mine mentioned by Dr. M., must be apparent from my statement of Ohm's law:

"That the intensity of the current is directly proportional to the electro-motive force divided by the resistance" (or, but inversely proportional to the resistance). Dr. M. calls this "disused language"—they are verbatim the words used by Prof. Ohm, of Nuremberg.

Besides, the whole tenor of the article shows that in the first remark quoted the word intensity was inadvertently misused for tension; for I mention later "that the intensity of the current corresponds to the quantity of electricity traversing the circuit, and that the quantity depends upon the surface of the metals and fluids and the degree of affinity existing between the parts composing the battery." And immediately after I explain the difference in density, saying that the density equals the intensity (of which I speak above as corresponding to quantity) divided by the transverse section of the conducting wire. Whoever makes such a statement, and explains these facts, will not be apt to mistake density and intensity, or to make a distinction between intensity and quantity, except by an error in writing.

In the same connection I draw the attention of the reader to essential and non-essential resistance. This proves that I was well aware of the resistance offered to the union of the two contrary electricities through the intermediate fluid within the cell (essential resistance), and that my statement "that they had no difficulty in uniting" simply alluded to the difference existing in the tension of static and dynamic electricity.

Dr. M. finally gives his explanation of the polarity of induced currents, finding fault with my statement concerning a change in the polarity of the currents. The deflections of the magnetized needle show that the current induced in the second wire on closing the circuit of the battery has a contrary direction to that of the current induced on opening it. A slight experiment will convince him that induced currents, when made to act upon water, show the following peculiarity: each wire serving alternately as positive and negative pole, both hydrogen and oxygen appear successively at either of the poles. The extra current always moves in the same direction, the induced current in the second wire moves alternately in contrary directions. I know well, that the latter current has *scarcely* any effect on closing, but a powerful action on opening the circuit; so that for practical purposes we need but take into consideration the current induced on opening the circuit, and this has the same direction as the battery-current. Besides, this can be easily tested by anybody taking hold of the two electrodes of an induction apparatus, as the difference in the strength of the two will at once become apparent.

Still, again, for practical purposes in medicine, we need not make such a distinction between the two poles of a faradic battery, as we do in a galvanic current, where it often is not the same, whether we employ an ascending or a descending current, whether (for instance in electrolysis) we apply the anode or the cathode at a given place. If we insist upon making a distinction between the negative and the positive pole of an induction apparatus, it would be only this: that the negative pole is placed where we wish a more powerful effect. But there are many extra currents developed in such an apparatus besides the prim-

ary current, and some of them do not pass through the cell; their consideration here, however, even if instructive to Dr. M., would lead me too far.

Having thus given the required information, it remains for me to reply to the Sanscrit reference, and to the general remarks of Dr. M. on the obscurity existing amongst the non-teaching medical confrères. I can only express my regret that Dr. M. did not grasp the contents of my lecture as a whole, otherwise the occurrence of a *lapsus linguæ* would not have seemed like Sanscrit to him.

HUGO ENGEL, M. D.

Philadelphia, Oct. 18, 1884.

To Disguise the Taste of Quinine.

EDS. MED. AND SURG. REPORTER :—

I have recently made some experiments regarding making quinine in solution palatable—a problem interesting to every physician in malarious districts. Palatable medicines are taken with a regularity which alone is worth the extra trouble required in compounding them.

Five grains of sulphate of quinine were extemporaneously mixed with or dissolved in the following:

1. "Quineptus," ℥ ss.
2. "Fluid ext. licorice for quinine mixtures" (Parke, Davis & Co.), ℥ ss.
3. Cascara cordial (P., D. & Co.), ℥ ss.
4. Cascara cordial (P., D. & Co.), ℥j.
5. Syr. yerba santa. arom. (P. D. & Co.), ℥j.
6. Ac. tannic, gr. jss.; syr. rhei arom., ℥j.
7. Ac. tannic, gr. jss.; syr. rhei arom., ℥j.

No. 1 had no taste of quinine and no aftertaste. No. 2 was bitter. No. 3 had no bitterness at first, but left an after-taste in the mouth. No. 4 had slight quinine taste and bad after-taste. No. 5 had a scarcely perceptible bitterness and no aftertaste. No. 6 had a deeper shade of bitterness than No. 5, but would be equally palatable to many persons from its flavor. No. 7 was similar to No. 1.

I think that No. 1 or No. 7 would be the preferable menstruum were it not for the large amount required, which is repugnant to many. A small quantity of No. 1 followed by a drink of water is very efficient to remove the after-taste. No. 5 and No. 6 were so very nearly equal to Nos. 1 and 7 that their smaller dose make me greatly prefer them. The combination in Nos. 6 and 7 was suggested to me by E. H. Robinson, M. D., of Lawrenceville, Ill.

The desideratum is a menstruum, a drachm of which will cover five or six grains of quinine, which may be allowed to stand in combination with it for a week or so, and which may not be incompatible with other fluids that we may wish to combine with the quinine. I do not believe a satisfactory menstruum for disguising quinine has yet been invented.

G. WALTER BARR, M. D.

Bridgeport, Ill.

Twin Labor—Mummified Fœtus.

EDS. MED. AND SURG. REPORTER:

September 1, I attended a mulatto woman in her third labor (three and five years respectively being the previous labors). After the parts were dilated, the unyielding membrane was ruptured, and a seven-pound girl was soon born.

Fifteen minutes afterwards the placenta passed, to which was attached a mummified male fœtus, which appeared to have been about three months advanced at its death.

The living child is now doing well, although during the first week it was troubled with jaundice.

W. F. ROCHELLE, M. D.

Jackson, Tenn.

NEWS AND MISCELLANY.

Disinfecting the Sputa of Phthisis.

Dr. J. Sormani, Professor of Hygiene at the University of Pavia, gave some interesting details at the Hygienic Congress of the Hague concerning experiments made this year on one hundred and fifty guinea-pigs with the sputa from phthisis. The obect in each case was to ascertain what chemical or other methods would neutralize the bacillus, which it was previously ascertained existed in large numbers in the sputa. The results of these experiments were summarized in the following manner:

1. The bacilli of tuberculosis were generally very difficult to destroy; dryness, exposure to oxygen, putrefaction, and most disinfectants, failed to produce any effect.

2. A temperature of 100° C. only killed the bacilli after at least five minutes of ebullition.

3. The artificial digestion of bacilli showed that they were the last of all living organisms to be destroyed by the gastric juices or chlorhidric acid. A very active digestion is necessary to kill this microbe. A healthy man may destroy the bacilli in his stomach, but an infant or an adult with his digestive faculties impaired would easily allow the germ to pass the stomach intact, and retain its virulence in the intestinal tube. This determined enteric ulcerations, etc.

4. The bacillus of tuberculosis can be preserved intact for a whole year when mixed with water. It is probable, though not proved, that it has retained its virulence during that time. Thus drinking water may become the means of propagating tuberculosis. It is probable that contaminated linen retains its virulence for five or six months.

5. Alcohol does not destroy the germ, and hard drinkers often suffer from tuberculosis.

6. Cod-liver oil, ozone, oxygenated preparations, and other similar remedies, have no effect in killing the bacillus, nor are benzoate of soda, salicylate of soda, sulphate of zinc, and carbolic acid, iodide of silver, bromides, camphor, etc., of much greater use. They injure, perhaps, but do not absolutely destroy the bacillus, at least in the doses that can be taken without danger.

7. A more decisive action may be attributed to creasote, eucalyptol, pure carbolic acid, the naphthols, and bichloride of mercury.

8. For disinfecting spittoons, carbolic acid solution at 5 per cent. is thought sufficient, and Dr. Sormani asserts that the breath never contains any bacillus. He also suggests that essences of turpentine or eucalyptol should be diffused in the

house as an agent for the destruction of this special germ.

Roman Remains in England.

Dr. William O'Neill writes to the *Lancet*, September 27, 1884, that while some workmen were recently opening up a new mining shaft near Lincoln, they came upon the remains of a Roman villa, two or three feet below the surface of the ground. From the nature of the diggings, much unavoidable damage had been done to the remains; but this much could be made out from the present excavations: that between two walls, running a considerable distance north and south, and fifteen yards apart, several apartments existed, as indicated by walls, tesselated pavements and large tile pavements. From these apartments three or four steps led down to a bath-room. The bath-room seemed to have been the front and most advanced basement room of the villa, and looked southward. From east to west the room measured about fifteen feet, and from south to north ten feet. From the east end of the north wall of the room, the bath extended seven feet southwards along the east wall. The bath was between three and four feet in breadth, and its sides rose from the floor about two feet. The floor of the bath-room was formed of a beautifully white tesselated pavement, the tesseræ being about an inch square. The tesseræ of the bath-room were made of white china clay, and were set in concrete. Tesseræ resembling those of the floor were extended up the side of the walls for a few inches, to form a dado. A dado has not been hitherto found in any other Roman building in England. In this case it was probably placed round the room to protect the lower part of the walls from the bath water. Tesseræ were also extended up the outside of the bath; the inside of the bath was formed of the same material as the tesseræ, but was quite smooth. The well-plastered walls of the room were painted a creamy white, and the bordering of the walls and other decorations were painted with the greatest neatness and precision in fine reds, yellows, greens, blues, and blacks. On one piece of plaster there was the picture of a swallow, nicely drawn and painted. Two or three feet north of the bath-room, but in a different apartment, is a very deep well seven feet in diameter, which is still in a comparatively good state of preservation. The water of this well no doubt was used in the bath-room, and from the bath-room a well-constructed drain-pipe carried off the waste water. The house must have been the property of a Roman gentleman of taste and opulence. The site was well chosen; but, in consequence of the villa being built on the brow of a hill, the lower rooms were on different planes. The ancient Romans evidently had remarkably good ideas of sanitation. This villa was built on a mass of three layers of different kinds of concrete, to the depth in some places of upwards of three feet; and the drainage of the whole premises seemed, as the workmen remarked, to have been perfect. The workmen, in clearing away the soil immediately outside the villa, came upon a skull and some human bones, among which there was a tibia presenting a united fracture.

An Oyster Mistaken for a Malignant Growth.

Dr. Theobald relates the following incident at one of the Baltimore medical societies, according to the *Archives of Ophthalmology*. A patient having suffered from some obscure symptoms sought medical advice for the relief of her sufferings. A suspicious-looking mass was discovered blocking up the posterior nares. This was removed without difficulty, having, apparently, sloughed off from its former attachments. The supposed neoplasm being regarded as probably of a malignant character, it was deemed of the first importance that its histological structure should be made out. A portion of the tissue was teased out and submitted to a microscopical examination. This completed, the growth was exhibited to the society in question, its histological characteristics were duly set forth, and the clinical facts of the case related. An animated discussion followed, and more than one hypothesis was advanced to account for the unusual features which the case presented. While this was in progress, an inquisitive individual, with microscopical proclivities, inspected the tumor with more care than had previously been thought requisite. The debate was suddenly cut short by the announcement that the suspicious neoplasm was, after all, but a half-digested oyster, a harmless specimen of our should-be familiar bivalve, which, probably, during a previous spell of vomiting, had become lodged at the point where it was discovered.

A Mediæval Instrument for Preventing Coitus.

To the late meeting of the American Gynæcological Society Dr. Thomas showed a relic of the Middle Ages, in the shape of a contrivance for preventing women from indulging in intercourse. It had lately been given him by a friend, by whom it had been found in the bottom of one of a number of trunks that constituted, with the odds and ends which made up their contents, the remnants of an estate in Europe that he had been called upon to take charge of. The apparatus resembled the well-known ivory affair that was furtively exhibited to tourists at the Hôtel de Cluny. It consisted of a jointed iron belt, to encircle the hips, to which a rigid strip of iron was connected before and behind, somewhat after the manner of a T-bandage. This strip of iron was widened where it passed over the vulva, and at that place there was a slit-like fenestra with a serrated edge, the teeth being bent somewhat outward. At the situation of the anus there was another perforated expansion, circular in this instance, and that opening also was serrated. The whole was covered with ancient-looking velvet. The strip of iron which passed between the thighs was hinged to the pelvic girdle in front, but behind (perhaps to add to its discomfort) it was secured with a lock. The original lock was a remarkable antique, and bore the emblems of high nobility—perhaps royalty. On that account his friend had desired to keep possession of it, and therefore he (Dr. Thomas) had replaced it with a small modern padlock.

The Inscription on Charles Reade's Tomb.

"The following," writes a correspondent, "is an exact copy of the inscription on Charles

Reade's tombstone, for the accuracy of which I can vouch. It was written by himself:"

HERE LIE
BY THE SIDE OF HIS BELOVED FRIEND, THE MORTAL REMAINS OF
CHARLES READE,
DRAMATIST, NOVELIST, AND JOURNALIST.
HIS LAST WRODS TO MANKIND ARE ON THIS STONE.

I hope for a resurrection, not from any power in nature, but from the will of the Lord God Omnipotent, who made nature and me. He created man out of nothing, which nature could not. He can restore man from the dust, which nature cannot.

And I hope for holiness and happiness in a future life, not for anything I have said or done in this body, but from the merits and mediation of Jesus Christ.

He has promised his intercession to all who seek it, and he will not break his word; that intercession, once granted, cannot be rejected, for he is God, and his merits infinite; a man's sins are but human and finite.

"Him that cometh to me I will in no wise cast out." "If any man sin, we have an advocate with the Father, Jesus Christ the Righteous; and he is the propitiation for our sins."

Cutting the Horns of Cattle.

One of the English Courts of Appeal has recently decided that the practice of cutting off the horns of cattle close to the head is cruel and unjustifiable. It was claimed in defence of the practice that it prevented the cattle from injuring one another when feeding in the yards, and secured for them a higher price. This reasoning was not conclusive with the judges, and they have decided that it must be discontinued. In this country the practice does not appear to be a common one, but the courts in any case before them would no doubt come to a similar conclusion.

A Dentist's Revenge—What it Cost Him.

A curious case is presented in one of the San Francisco courts. It seems that a dentist agreed to fill the teeth of a patient for $17.50, but after the work was done made his charge $22.50. Payment of this sum being refused, he forcibly removed the fillings. Suit was then brought by the patient for damages, and a verdict has been rendered against the dentist for $217.50, together with the costs of the suit.

Items.

—The Pope has given $200,000 for the erection of a new hospital at Rome, near the Vatican.

—Menthol has been used with success for ringworm, both in the form of a solution and pomade.

—It is proposed as a measure of economy to burn the dead paupers of Brooklyn, instead of, as is at present the practice, burying them in two-dollar soap-boxes.

—The sum of 40,000 francs has been left to the Faculté de Médecine, Paris, to found a biennial prize in hygiene. The sum of 10,000 francs has been left for a prize in histology.

—Dr. Don Rafael Zaldivar, President of the Republic of San Salvador, is said to be a very accomplished physician. He has just been chosen for a third term, and is now traveling in Europe.

—The Chicago Medical Society announces that there is now a collection of twelve hundred standard medical works in the Public Library.

—It is stated that so little faith does Dr. Klein now possess in Dr. Koch's germ-theory, that, ten days ago, he tested the question personally by swallowing a quantity of bacilli, without any evil result.

—The death of a child, aged two and a half years, recently occurred in England, from the sting of a wasp on the arm. Severe inflammation of the limb set in, and in four days the fatal result took place.

—Curci has shown, by trepanning experiments on dogs, that chloral, chloroform, ether, paraldehyde, and quinine produce anæmia, whilst morphia and nitrite of amyl cause hyperæmia of the brain. Atropine in small doses has but little effect; in larger doses it is rather an "anémiant."

—The death is announced of Mr. John N. Radcliffe, M. R. C. S., one of the best of modern epidemiologists. He was the author of a number of painstaking reports upon epidemics, being especially skillful as a historian in that line. He was for some years one of the two public health inspectors of London.

—Dr. John L. Dickey, of Wheeling, reports, in *The American Journal of Medical Sciences* for October, the history of a case of glioma retinæ. He appends a summary of the literature of this subject, which shows that most gliomatous tumors originate during fœtal life, and that permanent recovery is extremely rare.

—Dr. Howard A. Kelly, of Philadelphia, reports, in the October number of *The American Journal of Medical Sciences*, a case of the occurrence of ascaris mystax in the human body. It is believed to be the ninth case on record, and the first observed in this country. Dr. Kelly believes that it is simply an accidental parasite in the human body, and that it is probably but one of the rarer of the risks from using food contaminated by filth.

—Dr. S. J. Allen, in a paper read at the Vermont Medical Society, stated that during four years active service in the American civil war he was very seldom able to localize the position of a bullet by means of a probe; which, indeed, he considers only of service for determining the direction the ball has taken from its point of entrance, and whether it has entered a cavity. Used beyond this, it will do harm. But successful exploration may almost always be made by means of the smallest-sized exploring needles, which may be repeatedly passed in, in different directions, without any danger and with little or no pain.

—Prof. Chapman says the credit of demonstrating the functions of the anterior and posterior roots of the spinal nerves belongs to Magendie, and not to Sir Charles Bell. When Magendie, in 1821, published the correct idea, Bell collected and destroyed, as he thought, the whole edition of his own pamphlet, printed in 1811, which advanced the idea that the posterior roots are trophic only, and quickly published another containing the true idea. Prof. Chapman has seen a copy of Bell's treatise of 1811 which escaped destruction, and is now owned by the celebrated Richard Owen.